Children's
Advocate
Report

It's Time for a Plan for Children's Mental Health

April 2004

Children's Advocate Office

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The Saskatchewan Children's Advocate Office

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The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The reviews contained in this report were conducted, and this report is published, in accordance with this legislation.

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Executive Summary

Why a report on Children's Mental Health Services?

This report, *It's time for a Plan for Children's Mental Health*, is intended to build a broader understanding of the issues faced in the delivery of mental health services for children and youth in Saskatchewan today. Issues or concerns regarding the quantity, quality, and accessibility of mental health services for children and youth in Saskatchewan have been repeatedly raised with the Children's Advocate Office (CAO) over the past several years. We must also note that the number of specific, individual complaints received by our Office has been relatively modest (23 individual complaints between 1999 and 2001; 9 in 2002; and a further 6 in 2003). However, the issues presented by the individuals contacting us have been of a compelling nature. The Children's Advocate Office first raised publicly the issue of access by children and youth to mental health services, in the Children's Advocate 1996 Annual Report, *Advocacy With and For Children a Shared Responsibility*. In addition, issues regarding mental health services were identified by a number of community members in the *Children and Youth in Care Review: LISTEN to Their Voices (2000)*. More recently, co-ordinated and integrated planning for children and youth with mental health and child welfare needs has been recommended by this Office through our review of several child deaths, specifically deaths by suicide.

The CAO 2001 Annual Report, reported that access to mental health services for children and youth is one of several systemic issues that this Office has identified. We also reported, in 2001 and 2002, progress toward clarifying the issue and raising the profile and awareness of the Children's Advocate Office with child and youth mental health service providers. Of note in 2002, the CAO also received a request from the Saskatchewan Party Caucus to pursue a review of the adequacy and availability of mental health services for youth in Saskatchewan.

What is not included in this report!

This report is not intended to represent a collective or consensus view; rather, it is meant to be a catalyst for increased action in the area of child and youth mental health services. The CAO did not invite or include any written submissions, nor did we review or evaluate services provided to any individual children or youth. There is a real need for data on the services actually provided to children and youth and a need for an evaluation of the effectiveness of most services. We believe completing this evaluation is the responsibility of Saskatchewan Health and the Regional Health Authorities.

Have Mental Health Services for children and youth ever been reviewed before in Saskatchewan?

Not surprisingly, there have been a number of reviews completed in the past. Indeed, in 1983, the Task Force Committee on the Mental Health Services in Saskatchewan released its report *The Forgotten Constituents* (MacDonald Task Force). It is interesting now in 2004, over twenty years later, to review the recommendations made in 1983. The recommendations made by the MacDonald Task Force are still relevant today.

What is "mental health" and how is it defined in this report?

This question is not new for Saskatchewan and the report describes some of the dilemmas in defining mental health, including a comparison of the clinico-medical and population health models. The definition of mental health depends on what is considered to be within the scope of the concept of healthy living. For the purposes of this report, mental health for a child or adolescent is seen as:

> *the capacity of a child or adolescent to meet culturally normative developmental milestones by engaging in activities of normal development,* fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem.

What do we know about best practices in child and adolescent mental health and how do these relate to what we know about services in Saskatchewan?

Understanding best practices relative to fostering mental health and addressing service-delivery systems requires a systematic approach. This report is organized according to the eight key elements Health Canada has identified as important to consider when attempting to reduce inequities in health status and improve the general health status of the population.

1. **Focusing on the Mental Health of Children and Adolescents.**
   There is a dearth of research in Canada and in Saskatchewan on key indicators of mental health. In addition, Saskatchewan has an extreme shortage of clinicians and researchers who are trained and practice in the area of child and adolescent mental health (Conway, 2003).

2. **Addressing the Determinants of Health for Children and Adolescents.**
   It is difficult to track determinants of health in relation to mental health statistics, and this generally has not been a primary focus in Saskatchewan. Saskatchewan does not have an adequate system for tracking the prevalence

of mental disorders for children and adolescents or for tracking the proportion of children and adolescents who access mental health interventions for their problems. When we consider that the prevalence rate for having a mental disorder for children and youth is estimated in the literature at about 15% and when we apply this hypothetically to Saskatchewan, we find that mental health services, as provided through the Regional Health Authorities, are provided to only about 10% of the 42,488 children and adolescents in Saskatchewan estimated to have a mental disorder.

In addition to consideration for the prevalence of mental disorders, there are environmental determinants that may have a significant impact on the capacity of a child and family to achieve well-being. These include variables such as our higher than the national average teen pregnancy rate and infant mortality rate.

3. **Evidence-based Practice for Child and Adolescent Mental Health.**
It is recognized that service delivery to children and youth occurs across a broad range of therapeutic venues, including schools, clinics, correctional facilities, child protection systems, or primary healthcare settings, among others. Evidence-based practice, while desirable, requires special considerations and a greater complexity of research design than is typically acknowledged.

4. **Investing Upstream for Child and Adolescent Mental Health.**
A number of population-based prevention programs have been effective, including home-visiting programs, high-quality early childcare and education, prenatal programs, school-based programs, well-supervised recreational activities, and others. These early intervention programs should be guided by empirical research.

5. **Applying Multiple Strategies in Addressing Child and Adolescent Mental Health.**
No one approach to mental health development will address all needs and problems which children, adolescents, and their families encounter. Attempts to address and improve population health determinants across a broad spectrum of social concerns are necessary and integral to the optimization of mental health for people in Saskatchewan. It is clear that mental health services to children and adolescents must become less fragmented and more coordinated/integrated across government departments and service-delivery agencies. Four key strategies for addressing child and adolescent mental health service delivery are detailed in this report. These are: (1) integration of mental health services with primary health care; (2) integration of services with schools; (3) family involvement in the mental health system; (4) integrated case management and other collaborative models.

6. **Collaborating Across Sectors and Levels to Address Child and Adolescent Mental Health.**
   It is recognized that if collaboration across sectors and levels is to occur, those sectors will each have procedures, guidelines, and protocols that will have to be altered to remove barriers to inter-agency collaboration. Steps have been taken in Saskatchewan to achieve less fragmentation through the Integrated Case Management Model and a Complex Case Management initiative, but more work needs to be done. Accessibility to services continues to be a problem, particularly for children and adolescents who require services in rural and remote districts. This report did not even begin to address the badly needed improvements in determinants of health for First Nations children and adolescents in our province. Cultural competency of service providers has been identified as crucial to effective service delivery to persons of cultures differing from that of the majority population.

7. **Employing Mechanisms for Public Involvement in Child and Adolescent Mental Health.**
   Including public input into planning and decision-making regarding health services, including mental health services in certainly not a new concept in Saskatchewan. It is difficult to ascertain what action, if any, has been taken in response to recommendations already made by citizen-based advisory bodies such as the former Saskatchewan Council on Children or the Saskatchewan Mental Health Advisory Council.

8. **Demonstrate Accountability for Outcomes in Child and Adolescent Mental Health.**
   Demonstration of accountability for outcomes in child and adolescent mental health fundamentally necessitates information gathering and management in a manner that provides meaningful, useful data for system outcome evaluation but that continues to respect the privacy of persons accessing the mental health or other publicly funded initiatives. In order to be able to evaluate program goals and effectiveness, a broad-based level of financial, infrastructure, and personnel support needs to exist. Evaluation also requires that service-delivery process and outcome indicators be identified and tracked so that management and staff are able to see what works in service delivery and what does not.

What conclusions has the Children's Advocate Office reached?

The Children's Advocate Office has identified several issues with the current mental health system in Saskatchewan which we believe require further analysis and then action. In summary, we have concluded that there is a need to:

- Create a comprehensive data collection system that is consistent with a population health model and track and report on the status of child well-being and the prevalence of mental disorders in children and adolescents.
- Implement a more co-ordinated integrated system across government departments, service delivery agencies, professional disciplines and administrative structures.
- Train, recruit and retain qualified mental health professionals.
- Make resources for child and adolescent mental health services a higher priority in the health care system.
- Continue to support public education, prevention and early intervention research and services.
- Fit the service to meet the needs of the child rather than focussing on fitting the child or youth into the existing service delivery system.
- Engage parents, children and youth themselves and other community members when plans of action are developed and implemented.

What recommendation has been made?

This report is intended to be a catalyst for creating a comprehensive plan of action to ensure adequate and appropriate children's mental health services throughout Saskatchewan. Our observations led us to conclude that we need a clear direction and vision for children's mental health services; a direction that reflects what is known about best practices and which includes data collection, analysis and an evaluation of the effectiveness of the services. We need to know that children are indeed accessing the mental health services and supports they need in a timely and effective manner. Right now, while there are some indicators of success, there does not appear to be a clearly articulated plan to ensure that all children, and their families, can access the supports or services they need.

Therefore, the following recommendation is made in accordance with section 24 of *The Ombudsman and Children's Advocate Act*:

> ***CAO Mental Health Services Recommendation 2004***
> That Saskatchewan Health, in consultation with stakeholders, develop and implement a comprehensive plan to ensure that mental health services are provided to Saskatchewan children, youth and families in a manner that is consistent with what is known about best practices.

What next?

The Children's Advocate is requesting that Saskatchewan Health provide a response to this recommendation indicating the steps taken to give effect to this recommendation by January 2005.

Introduction

Issues or concerns regarding the quantity, quality, and accessibility of mental health services for children and youth in Saskatchewan have been repeatedly raised with the Children's Advocate Office over the past several years. We must also note that the number of specific, individual complaints received by our Office has been relatively modest (23 individual complaints between 1999 and 2001; 9 in 2002; and a further 6 in 2003). However, the issues presented by the individuals contacting us have been of a compelling nature. The Children's Advocate Office first raised publicly the issue of access by children and youth to mental health services, in the Children's Advocate 1996 Annual Report, *Advocacy With and For Children a Shared Responsibility*. In addition, issues regarding mental health services were identified by a number of community members in the *Children and Youth in Care Review: LISTEN to Their Voices (2000)*. More recently, co-ordinated and integrated planning for children and youth with mental health and child welfare needs has been recommended by this Office through our review of several child deaths, specifically deaths by suicide.

In our 2001 Annual Report, we reported that access to mental health services for children and youth is one of several systemic issues that this Office has identified. We also reported, in 2001 and 2002, progress toward clarifying the issue and raising the profile and awareness of the Children's Advocate Office with child and youth mental health service providers. Of note, in 2002, we also received a request from the Saskatchewan Party Caucus to pursue a review of the adequacy and availability of mental health services for youth in Saskatchewan.

All of the above factors contributed to our decision to prepare this report. This report is intended to build a broader understanding of the issues faced in the delivery of mental health services for children and youth in Saskatchewan today. This report includes a comprehensive review of relevant literature, presented in a Saskatchewan context, where this was found to be possible. This report is not intended to represent a collective or consensus view; rather, it is meant to be a catalyst for increased action in the area of child and youth mental health services. We have not invited or included any written submissions, nor have we reviewed or evaluated services provided to any individual children or youth in this report. The documentation provided to us by Saskatchewan Health was found to be descriptive of the mental health services available for children and youth but did not provide a comprehensive overview of the services actually provided or an evaluation of the effectiveness of most services. We make one overall recommendation for future action.

In deciding to prepare this report, we needed to access the expert advice and experience of recognized and respected individuals in the field. We decided, in accordance with *The Ombudsman and Children's Advocate Act*, to contract the services of Dr. David Randall, Consultant and Advisor and Dr. Theresa Zolner, Researcher and Writer. A Statement of Duties for each of these contracted individuals is included as Appendix A.

Dr. Zolner, in consultation with Dr. Randall and the Children's Advocate Office, prepared the major sections of this report, while both provided expert analysis and advice as the report was finalized.

In addition, during this past year, staff in the Children's Advocate Office visited most of the child and youth mental health teams in the Regional Health Authorities. We noted that mental health workers are themselves very committed to providing quality services and indeed are looking for innovative approaches to meet the demands placed on them.

Officials in Saskatchewan Health were also consulted regarding the Terms of Reference for this project and were provided with an opportunity to offer comments and input into a preliminary report. This report is prepared as a public report in accordance with *The Ombudsman and Children's Advocate Act*. This report has also been formally provided to the Deputy Minister of Health in accordance with the Act.

It is anticipated that this report will inform members of the Saskatchewan public about best practices in mental health services for children and youth and will serve as a platform for action.

Part 1
Children's Advocate Office

Authority and Mandate

The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The mandate of the Children's Advocate is to promote the interests of, and act as a voice for, children when there are concerns about provincial government services. The Children's Advocate engages in public education, works to resolve disputes, and conducts independent investigations. The Children's Advocate also recommends improvements to programs for children to the government and/or the Legislative Assembly of Saskatchewan. The vision of the Children's Advocate Office (CAO) is to ensure that the interests and well-being of children are respected and valued in our communities and in government practice, policy and legislation.

Section 12.6 inter alia of *The Ombudsman and Children's Advocate Act* provides that:

(2) The Children's Advocate shall:
- (a) become involved in public education respecting the interests and well-being of children;
- (b) receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning:
  - i) a child who receives services from any department or agency of the government;
  - ii) a group of children who receive services from any department or agency of government; and
  - iii) services to a child or to a group of children by any department or agency of the government;
- (c) where appropriate, try to resolve those matters mentioned in clause (b) that come to his or her attention through the use of negotiation, conciliation, mediation or other non-adversarial approaches; and
- (d) where appropriate, make recommendations on any of those matters mentioned in clause (b).

(3) The Children's Advocate may:
- (a) conduct or contract for research to improve the interests and well-being of children;
- (b) advise any minister responsible for services to children on any matter relating to the interests and well-being of children who receive services from any department or agency of government;

The Ombudsman and Children's Advocate Act, Saskatchewan, Revised 2000.

Systemic Advocacy

I. Authority to Conduct

Systemic Advocacy is conducted by the CAO in accordance with the legislated mandate of the Children's Advocate. Section 12.6 (2)(b)(iii) states that the Children's Advocate shall "receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning services to a child or to a group of children by any department or agency of the government." Section 12.6 (3) further authorizes the Children's Advocate to "conduct or contract for research to improve the interests and well-being of children" and to "advise any minister responsible for services to children on any matter relating to the interests and well-being of children...."

II. Process for Identifying a Systemic Advocacy Issue

On a systemic level, the Children's Advocate Office promotes and advocates for changes to government practice, policy or legislation respecting the interests and well-being of children. The Office advocates for improvements to processes through which the interests and viewpoints of children may be expressed, considered, and respected by government when it plans and implements services that impact on children. In addition, the Children's Advocate may make formal recommendations to Saskatchewan government departments or agencies relating to the interests and well-being of children.

How do we decide an issue is "systemic"?
The following advocacy framework and principles guide the CAO in making decisions on whether to pursue a particular issue or concern as a systemic matter:

1. **Mandate.** The issue falls within the mandate and mission of the CAO and affects children and youth that the CAO has the legislated authority to serve.
2. **Issue Selection.** Children or youth themselves, parents or community members have brought the issue to the CAO in relation to their personal concerns. The issue, therefore, arises from or is informed by the citizens that we serve. The issue also involves a current law, policy or practice that in some manner fails to respect the rights or entitlements of children and youth. Criteria to consider include:
   - the gravity and severity of harm;
   - the benefits of modifying the system;
   - the enforceability of a remedy;
   - the relative chance of success;
   - cost;
   - fairness; and
   - agreement on the issue among various groups.
3. **Issue Prioritization.** The CAO must be prepared to adapt to ever-changing priorities.
4. **Issue Action.** For each issue chosen for action, there is a plan that includes the use of objective data and outcome goals.

Adapted from (Cole, D., 1997).

Issues identified for systemic advocacy are generated through a review of the individual concerns raised with the office by youth, community advocates and professionals. Most of the individual concerns raised with the Office are resolved satisfactorily and the CAO file is closed with no need for further action. However, while the individual advocacy file may be closed, broader issues may remain. There may be other children or youth who continue to be impacted by the law, policy or practice that was identified in one or more individual files.

CAO History and Actions Related to Mental Health Services for Children and Youth

I. Actions to Date

The Children's Advocate Office first raised publicly the issue of access by children and youth to mental health services, in the Children's Advocate 1996 Annual Report, *Advocacy With and For Children a Shared Responsibility*. Although the number of concerns raised with the CAO has been limited (23 between 1999-2001; 9 in 2002, 6 in 2003), the complaints have been compelling. In addition, professionals from within the mental health sector, as well as other child-serving systems, have raised general issues and concerns in this area with the CAO.

In 2001, the CAO redefined its systemic advocacy process. Access to appropriate mental health services by children and youth was identified as a priority area of concern. Specific issues identified included:

- Waiting times to access assessment and treatment;
- Appropriateness of some inpatient programs for child/youth patients and the need for child/youth oriented services; and
- The rights of the children/youth to participate in decision-making about the services provided to them.

The CAO identified two desired outcomes related to mental health services for children. These outcomes are that:

- Children and youth in all parts of our province have timely access to appropriate mental health services.
- Children and youth are informed of their rights in the mental health system, including their rights to privacy, to participate in case and treatment planning, and to an appeal process in the event of a disagreement about a decision.

Over the past three years, CAO staff have been working to address systemic concerns in this area. The CAO has met with the Mental Health Services Child and Youth Managers and has visited Mental Health Services agencies across Saskatchewan. In the spring of 2003, the CAO contracted Dr. Theresa Zolner and Dr. David Randall to complete a review of recent Canadian/Saskatchewan-based information/literature regarding the availability and effectiveness of mandated and other mental health services for children and youth.

II. CAO Recommendations Related to Mental Health Services for Children and Youth

In addition to our systemic advocacy work in this area, the Children's Advocate Office has conducted several reviews and investigations where issues related to mental health services were raised by the CAO. These reviews resulted in the CAO making 10 recommendations and some additional findings in the area of mental health services. The recommendations are listed on the following pages.

Children and Youth in Care Review: LISTEN to Their Voices

Completed in April 2000, the *Children and Youth in Care Review* was a comprehensive two-year review of the services provided for children and youth living in foster care. The Review consisted of an examination of the literature, along with public and individual consultations with more than 1,100 Saskatchewan residents and a review of a random sample of the files of children in care. Regarding mental health services, the CAO recommended:

Recommendation 5.3
That the Department of Social Services (now Community Resources and Employment) and District Health (now Regional Health Authorities), Mental Health, Child and Youth Services develop a concrete plan to ensure better coordination of services and the enhancement of cooperation at all levels of the two systems.

Recommendation 5.4
That children in care have their health needs carefully assessed, monitored and fully documented. The full range of health services that parents provide to their children must be maintained by government as parent, including regular health check-ups, up-to-date immunizations, dental check-ups and follow-up, as well as any specialized care required, such as eyeglasses, mental health counselling or orthodontic work.

Recommendation 6.4
That access to addictions services, child development, parenting assistance, and health care services is timely and co-ordinated between various service sectors.

In June 2001, the Department of Social Services (DSS, now the Department of Community Resources and Employment) officially responded to the *Children and Youth in Care Review*. The response outlined the department's plan for a redesign of the child-welfare system in Saskatchewan. The response did not specifically address each recommendation from the CAO report. Rather, the response identified seven goals for the redesigned system, including immediate actions and proposed directions for the future that, when fully implemented, would address all the recommendations from the CAO Review.

The CAO acknowledges that the Department has done extensive work in the redesign of the child-welfare system. The CAO is currently working on a follow-up to the *Children and Youth in Care Review.*

Investigations at Provincial Youth Custody Facilities

In 2000, the CAO investigated two reports of unfair and unreasonable treatment of youth in custody, which were, at the time, the responsibility of the Department of Social Services (DSS, now the responsibility of Corrections and Public Safety). One of the investigations led to two recommendations related to mental health services for youth in provincial youth custody facilities.

JH Investigation Recommendation #3
That psychological and psychiatric services be readily available in all facilities to assist facility staff to proactively assess and plan interventions, particularly for youth with repeated problem behaviour.

JH Investigation Recommendation #4
That the practice of using restraints on youth who are already segregated must be discontinued with exceptions strictly restricted to situations where a mental health professional has assessed the youth to be at immediate risk of self-harm.

The DSS responded to the CAO investigation with a commitment to re-write the Resident Confinement and Segregation Policy and Use of Restraint Equipment in Secure Custody Facilities. The DSS indicated that managing resident behavior at the facility was addressed by creating a room where youth can be segregated without being restrained.

The DSS further indicated that a high risk and violent Young Offender initiative was jointly instituted with the DSS, Health and the Health Districts. Six psychologists were hired to identify violent youth and provide service to them in custody facilities and the community. The new Youth Service Model that was introduced by the DSS was intended to increase support to youth in facilities and provide better case planning for community reintegration.

Summary of Child Death Reviews, 1996 to 1998

In 1996, the CAO began conducting independent external reviews of the deaths of children who were, at the time of their death or in the 12 months preceding their death, receiving services from the Department of Social Services pursuant to *The Child and Family Services Act,* or the *Young Offenders Act* (now the *Youth Criminal Justice Act*), or were attending a facility or a family child care home licensed under *The Child Care Act.* In February 2001, the CAO released a summary report of the themes and issues identified in child death reviews for the years 1996 to 1998. One recommendation and one finding in this report had direct implications for mental health services.

Recommendation CDR.28(97)
That the Departments of Social Services and Health establish a clear protocol for collaborative case planning for children and youth who are receiving services from both departments. It is further recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child or youth are being appropriately addressed.

Findings: Alcohol and Drug Use
While valuable programming and services are available for addicted children and youth, adults in Saskatchewan have access to a greater continuum of services. Adults can attend a variety of detoxification centres, inpatient centres, structured day programs, individual outpatient treatment, as well as relapse prevention programs. The CAO is concerned that children and youth do not appear to be provided with access to the same continuum of services as adults.

In February 2002, the then Minister of Social Services, Hon. Glen Hagel, provided a joint response, on behalf of the Departments of Social Services, Health, Justice, Education and Aboriginal Affairs, to all the recommendations in the report. With respect to recommendation CDR.28(97) and the finding regarding alcohol and drug use, the response provided the following information:

CDR.28(97): The Government presented several initiatives/activities that they have developed that address the issues identified in the recommendation. These include:

- The Coodinated Behaviour Management Initiative: Under this initiative, the response indicated that "it is Health's and Social Services' expectation that whenever a family with multiple and complex needs is receiving services from both agencies, an integrated case management process would be initiated."
- The Human Services Integration Forum struck the Human Services Integration Complex Case Protocol Task Team.
- The Youth Suicide Intervention and Trauma Response Program: A network of mental health professionals in 11 health districts to provide youth suicide prevention, intervention and psychosocial trauma response services.
- Integrated community-based services for youth with challenging psychosocial needs at the White Buffalo Youth Lodge in Saskatoon and the Randall Kinship Centre in Regina.

Alcohol and Drug Use: Regarding the CAO findings in this area, the Government responded that:

> Saskatchewan has a full continuum of services available for youth with substance abuse problems. In addition to providing direct counselling and intervention services, many agencies are involved in alcohol and drug awareness and prevention programs through the schools and other milieux. Most large urban centres such as Regina, Saskatoon, Prince Albert and Swift Current have counsellors devoted specifically to youth chemical dependency. Some community-based organizations such as the Metis Health & Addictions Council of Saskatchewan Inc. (MHACSI) have workers devoted to treating youth addictions.

> Youth with substance abuse problems are rarely chemically dependent and, therefore, do not require withdrawal management supports (i.e. detoxification). However, if required, detox services are made available to youth. Community-based services can address the majority of alcohol and drug problems of youth. It is felt that youth involvement in community-based (i.e., outpatient) programming, in contrast to placement in a residential facility, provides equally effective treatment outcomes... In order to provide services as close to "home" as possible, community-based outpatient services are accessible to youth in all 32 health districts throughout the province. Nine health districts provide specialized services for youth through Child and Family Service programs....
>
> The Calder Center Adolescent program is an inpatient recovery program specifically designed for adolescents between the age of 12 and 18 years. ... Twelve beds are devoted to inpatient treatment of youth. ... In addition, depending on individual need, youth can receive residential treatment services at Pine Lodge Treatment Center in Indian Head, Metis Health & Addictions Council of Saskatchewan Inc. (MHACSI) in Regina, Saskatoon and Prince Albert, and at the Walter A. "Slim" Thorpe Center in Lloydminster (Saskatchewan Social Services, [correspondence], 2002).

A Summary of Child Death Reviews for the Year 1999

In December 2003, the CAO released its second summary report on child death reviews for the year 1999. Several more recommendations were made in the area of mental health services.

> **Recommendation CDR.36(98)**
> That a review of the need for a residential psychiatric facility for children and youth in Saskatchewan be completed.

In July 2003, the Department of Community Resources and Employment responded to CDR.36(98) and stated: "Your recommendation that a review be completed on the need for a residential psychiatric facility for children and youth will be forwarded to the attention of appropriate officials in Saskatchewan Health. I assure you that my department will work cooperatively with Health in any review initiated by their department on this issue." Saskatchewan Health has not yet notified the CAO if they plan to complete such a review.

> **Recommendation CDR.49(99)**
> That the DSS, Saskatchewan Health and the Regional Health Authorities (Child and Youth Psychiatry Services and Addictions Services) jointly review the Saskatchewan Human Services Integrated Case Management model and create a process to ensure that it is implemented appropriately, including regular follow-up and review of identified children and youth requiring this service.

The Department of Community Resources and Employment and Health, with representatives from Regional Health Authorities, Child and Youth Services and Alcohol and Drug Services, reported to the CAO that they met in February 2003 to discuss the CAO recommendations regarding the need to implement and review the integrated case management model.

Following the meeting, the CAO was advised that "It is an expectation of DSS and Health that staff use an integrated case management approach and collaborate with other departments and agencies whenever there are several service providers involved with a family." They acknowledged that "every child or youth could benefit from integrated case management. However, it was the opinion of the group that integrated case management is very difficult to implement in every case, and especially difficult with high-risk youth who are often resistant to services and require considerable outreach to be engaged. Many also require out-of-home living arrangements. Nevertheless, we are pleased there has been significant progress in implementing an integrated case management approach in many areas." Progress was noted in many areas across the province.

However, full implementation of the model has not been achieved. In their response to the CAO, DSS and Health recognized "that more work needs to be done in the development of policy and programs that address the integrated service needs of children and youth who have serious substance abuse or addictions, mental and child welfare issues. Health and DSS have agreed to further discussions with [representatives from] the Human Services Integration Forum."

Recommendation CDR.55(99)
That the Department of Corrections and Public Safety amend the Young Offender Program, Policy and Procedures Manual (1994) to include a mandatory assessment of the youth's alcohol and drug use as a section of the initial assessment and case plan.

Corrections and Public Safety (CPS) accepted the CAO recommendation. On April 1, 2003 the *Young Offenders Act* was replaced by the *Youth Criminal Justice Act*. In preparation for the new legislation, the CPS produced draft policies and procedures for community dispositions. The CPS delivers supervision and support to youth sentenced to court ordered dispositions. The Department advised that their role includes general assessment, and case management.

Youth workers, as part of the case management policy, are directed to assess and refer to appropriate agencies to obtain needed alcohol and drug assessments. Effective April 2003, "a risk assessment system was implemented to identify substance abuse issues and flag cases that require follow-up." Regional Health Authorities and the Native Alcohol and Drug Abuse Programs have the mandate to deliver alcohol and drug assessment and treatment services. The CPS will not provide specialized drug and alcohol assessment services but in cases of substance abuse, both the treatment resources and the youth worker will work together to address the youth's needs. The CPS and Department of Health concur that this is the practice they will now be supporting and to which their staff will be trained.

Part 2
Background to Mental Health Services for Children and Youth

In 1983, the Task Force Committee on the Mental Health Services in Saskatchewan released *The Forgotten Constituents,* a report to the Mental Health Association in Saskatchewan (the MacDonald report) on a review of mental health services in the province. A number of mental health reviews had been conducted prior to 1983; however, the MacDonald task force attempted to address the issue of past inaction with regard to recommendations made in previous reviews. In particular, the MacDonald report attempted to track recommendations made in the Frazier report of 1968, a much-publicized review of provincial psychiatric services.

The MacDonald Task Force examined the following systems and issues (Task Force, 1983, p. 1):

1. existing mental health programs and services
2. how provision of the best treatment and rehabilitation services could occur for persons with psychiatric and emotional difficulties
3. how citizens of the province could be best equipped to cope with "problems, tension and anxiety in their lives"
4. how the province's social environment (including schools, rural and urban communities, families, work places and the status of women, children, elderly persons, and First Nations peoples) could be improved so as to promote mental health
5. how the province's physical environment (including water, food, air, soil, and substances used at work, home, or on the farm) could be improved so as to promote mental health.

The MacDonald Task Force (1983, pp. 1-2) identified a number of major problems in provincial mental health service delivery. First, the Task Force identified serious gaps in community programming which put increased pressure on inpatient programs for mental health service delivery. Second, the Task Force identified chronic recruitment difficulties for qualified staff, particularly psychologists, psychiatrists, and, to a lesser extent, social workers. Third, the Task Force identified continuing difficulties in providing services to persons termed "hard to manage," in part due to a shortage of community residential settings in the province.

In addition to these three major problems, the MacDonald Task Force pointed to a significant disparity between services available in urban versus rural settings, as well as a general lack of prevention programs or overall prevention strategy. Finally, the Task Force described services to the elderly, to First Nations persons, and to youth as "non-existent or grossly underdeveloped" (p. 8).

In response to identified problems, the MacDonald Task Force made seven major, urgent recommendations with regard to mental health service delivery, in addition to their call for the establishment of a Mental Health Advocate position to keep mental health services needs at the forefront of public interest. Those recommendations were identified as directly responsibilities of the Saskatchewan government and were as follows (1983, pp. 12-13):

1. Immediate allocation of a more equitable share of health funds for mental health services.
2. Urgent steps taken to facilitate the recruitment, retention, and training of mental health professionals in Saskatchewan should. [sic]
3. Development of residential rehabilitation and socialization programs in every mental health region, which would enable more people to remain in their communities.
4. Promotion of innovative and experimental prevention programs at both the governmental and non-governmental levels as well as acceptance by the government of its responsibility in this important area.
5. Development of standards of care, staffing, and measures of outcome evaluation for all tax-supported programs.
6. Recognition of government's need to promote education, prevention, and research as essential components of comprehensive health programs by funding preventative programs and by enhancing governmental research programs.
7. Establishment of mechanisms to ensure the coordination and integration of tax-supported mental health programs in every health region.

Although the MacDonald Task Force focused on mental health programming in general, it identified mental health programming for youth as a particular area of under-development in Saskatchewan. Unfortunately, in its seven urgent recommendations, the Task Force did not include specific direction on mental health service delivery to children and adolescents in the province. However, the Task Force reinforced in their report the importance of upholding the principles set out in the United Nations Declaration of the Rights of the Child. In addition, in their chapter on "Special Groups, Services, and Needs," the Task Force specifically addressed mental health service delivery to children and adolescents.

The recommendations regarding mental health services to children and adolescents were wide-ranging, addressing issues across the mental health, child protection, legal, recreation, education, health, prevention, and voluntary service-delivery sectors. Their recommendations were in keeping with the reality that the mental health problems of children and adolescents involve a variety of persons and services, including parents, educators, police, courts, social service workers, family physicians, psychiatrists, and clinical psychologists, with each group having its own unique perspective on children's needs and problems. Other groups and professions also could be added to this list.

The Task Force made the following 14 recommendations regarding mental health service provision to children and adolescents:

Macdonald Task Force Recommendations Regarding Mental Health Service Provision to Children and Adolescents

1. "That funds be provided to enable appropriate community-based agencies in each region to compile a comprehensive directory of mental health services for children and youth" (p. 82).
2. "That psychiatric services branch establish demonstration projects, to determine the most effective and efficient ways of providing special mental health services to children in rural areas" (p. 83).
3. "The immediate implementation of family support measures provided for in sections 6 and 7 of *The Family Services Act of 1973*" (p. 84), which enable parents who have children with special needs to access assistance in meeting their children's needs in the home rather than having those services delivered exclusively through out-of-home, child protection placements.
4. "That the recommendations of the Law Reform Commission of Saskatchewan regarding age of consent for health care (including counselling) be adopted in Saskatchewan law" (p. 85).
5. "That equitable foster care allowances, providing for substitute foster parenting, and reimbursement of all health care costs, be provided by all agencies supporting foster care programmes" (p. 86).
6. "That funding be provided to establish intensive recreational programmes for emotionally handicapped children during the summer months" (p. 87).
7. "That the Department of Education be allocated adequate funding to enable it to meet the demands for personal counselling and mental health consultation with teachers, designed to promote the mental health of students" (p. 88).
8. "That learning disabled and emotionally disturbed children be designated for high cost funding by regional panels consisting of mental health and educational professionals who specialize in these areas with representation from the children's parents and teachers" (p. 90).
9. "That additional funding be allocated for children who are designated low cost emotionally/behaviourally maladjusted children and that such funding be tied to service delivery" (p. 91).
10. "That the Department of Health address the problems of adolescent pregnancy and adolescent suicide through increased funds for public education, clinical research and specialized counselling services" (p. 94).
11. "That the Department of Health identify and provide specialized services to high-risk groups such as hospitalized children and children of psychiatric patients" (p. 94).
12. "That the Department of Health make major improvements in early diagnosis and screening services at specific developmental stages of the preschool and early school years" (p. 94).
13. "That a full range of outpatient and residential mental health treatment programmes be made available by the Department of Health in each region of the province" (p. 95).
14. "That the Psychiatric Services Branch provide project funds to the Mental Health Association to establish a demonstration rural voluntary mental health action group" (p. 97).

Since the release of the MacDonald Task Force report in 1983, health, mental health, social work, and educational authorities have undergone changes in funding, organization, and, in some cases, program philosophy.

In addition, considerable structural and funding changes have occurred specifically with service delivery to First Nations children, given the development of First Nations controlled Child and Family Services agencies funded with federal monies and operated independently from provincial health services.

While some of the recommendations have been implemented, others may not have been or may no longer apply. In addition, new problems likely have developed over the past 20 years that will require attention over and above the ones identified in the MacDonald report.

Furthermore, despite Saskatchewan Health reporting an increase in resources by over 50% for Children's Mental Health Services since the early 1990s, the demand for these services has continued to increase. In the mid-1990s, the incidence (30-40%) of Canadian children and families at risk for poor outcomes in life (including mental health problems) was estimated to be high (Government of Saskatchewan, 1993; Valpy, 1993 as cited in Saskatchewan Education, Training and Employment, 1994). Regionalization of health services in the province has occurred, and more recently the Saskatchewan Health Quality Council was created.

Recently, the Fyke and Romanow reports both made the case for primary health care as a first priority in Canada. The Saskatchewan Mental Health Advisory Council, in their *Annual Report to the Minister* (January, 2002), selected "children and youth mental health issues" as their primary focus for the following year.

Part 3
A Framework For Understanding Mental Health

Although the MacDonald report was released 20 years ago, it was forward-thinking in its recognition that the social and physical environments play a major role in the promotion and maintenance of people's mental health. In fact, the MacDonald Task Force identified both a fundamental set of beliefs or principles about health and mental health, as well as a set of characteristics for a good mental health service-delivery system.

The seven principles that should underlie a mental health service-delivery system, according to the MacDonald Task Force, are (1983, pp. 11-12) quoted as follows:

1. That health is 'a state of complete physical, mental and social well-being and not merely the absence of disease.'
2. That every individual has the right to expect an environment which promotes health both physically and psychologically.
3. That every person in Saskatchewan must recognize that they have a role to play in the maintenance of their own and everyone else's mental health.
4. That neither stigma nor blame should be attached to those suffering from mental illness.
5. That every person has the right to expect equivalent care, consideration and acceptance regardless whether they are suffering from a physical or mental illness.
6. That a comprehensive mental health programme should direct itself to prevention as well as to treatment and rehabilitation.
7. That a comprehensive mental health system should:
    a. Be sensitive to the changing mental health needs of the population it serves.
    b. Be accessible to all regardless of age, sex, cultural background or place of residence.
    c. Provide appropriate services for the diverse needs of its individual clients.
    d. Be effective and efficient.
    e. Be accountable to the public it serves as well as its funding agencies.
    f. Be conscious of the need for maximum community involvement in the planning and delivery of mental health services.

Principle seven identifies what the MacDonald task force identified as the basic characteristics of a strong mental health service-delivery system.

Ways of Defining Mental Health

The definition of mental health depends on what is considered to be within scope of the concept of healthy living. In their recent report to Health Canada on child and adolescent mental health, Peters, Lafreniere, and Digout (2001) identified two differing views about mental health that can result in competition for resources. Other views about mental health exist, including viewpoints fundamentally opposed to the concept of mental disorder or diagnosis; however, the two primary views, as identified by Peters, Lafreniere, and Digout (2001), will be discussed here.

I. The Clinico-Medical Model

The first point of view, the clinico-medical model, sees mental health as the absence of mental illness and identifies the existence of mental disorders, as well as their base rates, as the justification for the existence of services to address mental health needs. In this model, mental health problems are viewed as "disease states," which often are seen as having biological causes. Accordingly, this perspective places emphasis primarily on the need for treatment facilities and prevention programs to target the existence and prevalence of these disorders.

While the clinico-medical model of mental health often looks to biological causes, recognition exists within this model for the inter-relationship of biological and psychosocial factors. For example, clinical practice in mental health typically involves a psychologist or psychiatrist diagnosing the existence of a particular mental health problem. Psychologists and psychiatrists currently rely, for diagnosis, upon the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Textual Revision* (DSM-IV-TR), which was published by the American Psychiatric Association (2000).

The DSM-IV-TR contains within it five major sections, called axes, which encompass the following areas of clinical interest: clinical syndromes, personality disorders, general medical conditions, psychosocial and environmental problems, and global functioning. The goal of the DSM-IV-TR is not to identify necessarily the particular causes of a disorder but the existence of the disorder as well as the major factors in the person's life that have an impact on the development, maintenance, and prognosis of that disorder. Although clinicians may focus on the existence of a particular mental disorder, competent practice dictates that clinicians consider the broader scope of the person's life and health, including personal relationships, environmental factors, financial status, employment conditions, traumatic experiences, as well as a number of other psychosocial variables that come to bear on the mental health and general well-being of the person. In fact, a well-conducted and thorough psychological or psychiatric assessment involves consideration of all aspects of a person's life.

Given that the clinico-medical model in mental health has, at the core of its practice, identification and diagnosis of mental disorders, the model fundamentally requires professionals trained and licensed to perform diagnosis to be stewards of the service-delivery system.

As a consequence, mental health service delivery tends to become organized into units or systems that reflect the specialities of the persons treating the particular problems. In Saskatchewan, professional disciplines work together. For example, in some mental health services, clinical psychologists and clinical social workers work together on teams, which sometimes have psychiatrists assigned to them as well. However, more often the case is such that services are organized into professional units, for example "Psychology," "Social Work," "Speech and Language Pathology," and the like. Boundaries exist between professionals and volunteers or community-based resources as well.

Professional boundaries create a "specialist" orientation in mental health service delivery, even if the individual professional disciplines do not recognize official specializations in child or adolescent mental health care, such as is the case with clinical psychology. Nevertheless, clinicians tend to be organized into specialist units that focus on particular age groupings or types of problems within a particular discipline.

The specialist or expert orientation provides the opportunity for service delivery that is targeted towards specific kinds of interventions focused on individual persons. In fact, the diagnostic categories contained in the DSM-IV-TR tend to be focused primarily on diagnosis of disorders in individual persons rather than diagnosis of environmental problems or group/family-based problems. Within the DSM-IV-TR, possibility exists for parent-child problems, social problems, or environmental problems to be noted, but the diagnostic system fundamentally is individually oriented.

This poses a unique kind of difficulty for service delivery to children and adolescents because of their unique dependency on the persons and environments around them for developmental, social, and financial support. Sometimes intervention for child and adolescent problems can exclusively involve therapeutic activity with the young person; however, in most cases adult caregivers become involved with the intervention program. At times, those adult caregivers must be the focus of intervention, and at other times, children and adolescents need to be treated together with family members.

Services that offer the flexibility for the family or adult caregivers to become the focus of treatment can more realistically address the needs of children and adolescents than services that focus solely on the child or adolescent.

However, services based on the clinico-medical model less frequently engage in efforts to actively prevent or change social or environmental stressors that have an impact on mental health. Fundamentally, it becomes the role of individual people to make these kinds of changes in their own lives without support from larger societal initiatives.

One major weakness of the clinico-medical model, as an administrative focus in service structure and organization, is that people's access to service becomes highly dependent upon resource-driven planning.

This dependency can result in limiting persons' access to services because those services might be (1) restricted to certain settings, locations, or schedules/ times; (2) bound by agency procedures which might limit service to a specific group or number of sessions; and (3) under-funded or have funds directed only to certain kinds of services (Osher & Osher, 2002).

II. The Population Health Model

The second point of view, often identified as the "population health" perspective, defines mental health as not the absence of disorder but the presence of well-being, which is seen as a product of multiple determinants of health. The existence of disordered or disease states in the person comprises one cornerstone of the population health model; however, need for mental health services is viewed as arising out of a primary need to ensure that people, first and foremost, have access to adequate living conditions, as well as social and emotional supports. Adequate access to proper living conditions and social/ emotional support builds a foundation for well-being. Access to primary, life-sustaining supports ensures that people are able to carry on their daily activities in ways that are life-enriching and enables children and adolescents to thrive in their basic physical, social, cognitive, and emotional development.

Children are particularly vulnerable in this regard because they cannot directly and independently access the living conditions and supports that they need to ensure good developmental outcomes. Therefore, special attention needs to be directed towards identifying, measuring, and following-up on the availability of structures and services to support their growth and development. Sometimes this might mean creating or directing resources particularly to children. However, it might also mean creating or directing resources to the families and community in which children reside in order to provide children with what they need.

The population health perspective tracks multiple determinants of health, beyond just the presence or absence of disorders and factors that contribute to or maintain those disorders for children. The population health perspective

involves addressing children's needs in a multiplicity of ways, including advocacy, public information and education, health promotion, primary prevention, as well as multi-systemic forms of intervention across a broad spectrum of problems, both common and high-need, at the level of the child. This model is designed to identify and track both strengths and weaknesses at the level of the child, family, community, province, and the nation, as well as globally.

Recognition also exists within this perspective that mental health remains closely tied to a variety of factors beyond simply the cognitive, emotional, and physiological well-being of the child or adolescent. Health Canada has identified 12 primary determinants of health for Canadians of all ages, which inform what are seen as key areas of concern for and understanding of population health and the mental health of children, including:

- Income and social status
- Social support networks
- Education
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

Statistics Canada has incorporated determinants of health into its *Canadian Community Health Survey – Mental Health and Well-Being*, the first cycle of which was due to be released in summer 2003. The World Health Organization has also recognized, analyzed, and promoted determinants of health as critical to the understanding of both mental health and mental illness (WHO, 2001). WHO has also encouraged program development from this perspective, given that population health indicators are predictive of both physical and mental health outcomes.

A glance over the determinants of health list makes clear that child mental health is determined not just by what is directly relevant to children, such as biological and genetic endowment, healthy child development, and gender. In addition, children's mental health is fundamentally influenced by what happens in the adult world over which they have very little control. Adults can be profoundly affected by what happens in the life and world of a particular child. The hallmark of this model is recognition of the interdependence of factors both within and external to the person and very much tied to broader societal issues involving standards of living, working conditions, and other aspects of population health.

An understanding of what constitutes children's mental health inevitably must acknowledge that the worlds of children and adults co-determine each other's health, and the care of children cannot in any way be seen as unrelated to or separate from the care of the adults in their lives. For example, a population health perspective would have little difficulty acknowledging that caring for a child with behavioral problems likely will require service delivery to the parent of that child more so than directly to the child. Although the child might have a diagnosis of Oppositional Defiant Disorder, for example, the treatment for this condition might involve parenting therapy rather than therapy and intervention directly given to the child. Practitioners of the clinico-medical model will also recognize this; however, it is not so much practitioners that have problems with these kinds of scenarios, as it is service-delivery mandates, which often dictate that child-directed services cannot involve primary intervention to parents. Children and adolescents do not live in a vacuum, so child and adolescent services must inevitably have a broad enough mandate to be able to address families and their multiplicity of needs.

Recognizing the reality of the interdependence of the child and adult worlds, the Bazelon Center for Mental Health Law issued *Principles for the Delivery of Children's Mental Health Services*, which arose after a 2001 court decision in an Arizona class-action lawsuit regarding children's access to mental health services. The first and cornerstone Bazelon principle for service delivery calls for "collaboration with the child and family," where parents and children are seen as collaborators and partners in the assessment, planning, delivery and evaluation of mental health services.

Therefore, recognition of the role of family and social context for the child is just one of the ways that advocates of the population health approach to mental health can broaden the nature of service delivery to children and adolescents. The population health approach also recognizes that health is not a state but a capacity or resource (Health Canada, 2002). The population health approach is particularly meaningful to understanding the mental health of children and adolescents because they are especially vulnerable to circumstances in their social worlds given their high level of dependency on the adults around them (See also, Waddell, McEwan, Hua, & Shepherd, 2002; Landy & Kwan Tam, 1998). In addition, child and adolescent experiences and mental health can affect later health outcomes in adulthood as well as inter-generationally. Evidence exists to support the idea that children and adolescents are affected by macroeconomic conditions, social context, and social policy. Phipps (1999) accessed national data sets from studies in three countries, Norway, Canada, and the United States, and compared them on the following variables:

1. micro-level socioeconomic characteristics (e.g., family structure, child's age, child's gender)
2. macroeconomic conditions (e.g., regional unemployment rate)
3. social context (e.g., percentage of the population who are immigrants)
4. social policy (e.g., social spending per capita)

Phipps found evidence that policy has an impact on children, but she found that the impact could not be assessed through ordinary, micro-level variables. Phipps' findings underscore the complex relationships that exist between socioeconomic variables and the mental health of children and adolescents. Health Canada (2002) has identified key elements that define a population health approach to Canadian health maintenance and improvement. These key elements include a system's ability to:

1. Focus on the health of populations
2. Address the determinants of health and their interactions
3. Base decisions on evidence
4. Increase upstream investments
5. Apply multiple strategies
6. Collaborate across sectors and levels
7. Employ mechanisms for public involvement
8. Demonstrate accountability for health outcomes

Although inherent to an understanding of population health is the understanding that physical and mental health are not completely separable, Health Canada commissioned Frankish, Bishop and Steeves (1999) to identify a population health approach to mental health that might clarify this relationship.

Identifying both benefits and challenges to taking on a population health perspective in mental health, Frankish, Bishop and Steeves (1999) concluded that doing so would allow for enhanced coordination of services as well as more comprehensive service availability for Canadians, instead of the rather fragmented system which most populated areas endure. They also pointed out that, in some ways, a population health perspective is more in line with, and a better overt articulation of, how many mental health practitioners have always tried to provide service.

One weakness of the population health perspective is that it is a "perspective" and not a service-delivery model. There is no existing central authority that has responsibility and accountability for the implementation of this perspective, which is more of a paradigm than a model. In order to implement a population-health approach to mental health service delivery, a population health perspective would have to permeate a number of key stakeholders, including health, education, corrections, recreation, environment, child protection and others.

Population health would have to become a central vision for setting goals and objectives: A population health perspective only in child and adolescent mental health services would defeat the entire purpose of the approach in the first place.

In Saskatchewan, a clinico-medical model of service delivery already exists and is well-entrenched. In fact, the clinico-medical model forms a fundamental aspect of the social script in our province and society in general. While proponents of the population health model certainly attempt to be comprehensive in its articulation of important factors to consider relative to mental health, a Saskatchewan-based model for service delivery would need to be developed in keeping with this perspective in order for it to work. Development of a model for service delivery would best address multiple determinants of health, while recognizing and incorporating the strengths and benefits of practice in the clinico-medical model.

III. A Balanced Perspective

It might seem tempting to set the clinico-medical model and the population health perspectives against each other in an effort to determine which has greater merit. However, each approach has its particular strengths and weaknesses, as well as differing philosophical underpinnings. In addition, it is possible in either system to achieve relative imbalance in terms of intervention versus prevention or biological versus psychosocial emphasis. In practice, those who espouse the clinico-medical model are not naïve to the importance of psychosocial and environmental factors in people's lives. Likewise, those who espouse a population health approach are not naïve to the importance of individual determinants of health and the unique impact of individual genotype, temperament, and lifestyle.

The key to an adequate model of mental health service delivery is to recognize the impact of a multiplicity of factors on people's well-being and the importance of treating the person not in a vacuum but as a participating member of society who has important strengths and weaknesses and who lives in a socio-cultural environment that, itself, has important strengths and weaknesses.

Some work in this area has already been accomplished by Tymchak and the Saskatchewan Instructional Development and Research Unit (2001) in terms of the School^{Plus} model for education, which is discussed in greater detail later in this report. In addition, the Mental Health Services Branch identified, in their *Core Services* (1990) document, a conceptual guide to mental health services that could encompass both the population health and clinico-medical service delivery models along two axes.

Figure 1 outlines the Mental Health Services Branch represention of the two axes and four quadrants. One axis focuses on "optimal/minimal mental health." The other axis focuses on "maximal/absent mental disorder." The two axes divide concerns regarding mental health service delivery into four quadrants. The conceptual guide was derived from the 1988 Health and Welfare Canada report, *Mental Health for Canadians: Striking a Balance,* to which the province of Saskatchewan has demonstrated commitment.

Figure 1. Conceptual Guide to Mental Health Services

OPTIMAL MENTAL HEALTH

Clients: Disabled Focus: Rehabilitaion Branch Roles: Coordination Facilitation (funding) Direct Service	Clients: Community Focus: Mental Health & Well-Being Branch Roles: Health Promotion Community Empowerment
Mental Disorder	
Clients: Acutely Ill/Traumatized Focus: Treatment and Care Branch Roles: Major Service Provider Coordination Regulation	Clients: Distressed & Vulnerable Focus: Treatment & Enhancing Skills and Supports Branch Roles: Service Provider Advocacy Community Development Facilitation (funding)

MAXIMAL — ABSENT

MINIMAL MENTAL HEALTH

Branch Major Service Provider

Branch & Communities Share Responsibility for Services

Communities Major Service Providers

Adapted from: Mental Health for Canadians: Striking a Balance (H&WC 1988) MHSB, 1990 (p.5)

The Mental Health Services Branch has been restructured since 1990 and it is difficult to ascertain exactly what conceptual framework is being used for children's mental health services in Saskatchewan at this time.

Since the authority to deliver mental health services was transferred to the health districts (now regional health authorities) in the mid-1990's, Saskatchewan Health has reported that planning for child and youth mental health services has been done under the framework of the Saskatchewan Health Plan and the individual regional health authority plans.

Recently, the Province of Newfoundland and Labrador also released a framework for development of a provincial mental health policy. The authors of the Newfoundland and Labrador framework pointed to the interaction of facts determining both mental health and mental illness. They placed the two related dimensions together within a quadrant system in an effort to demonstrate the interrelationship of the dimensions, with two continuous axes resulting: "Good mental health – Poor mental health" being one axis and "Severe mental illness – No mental illness" being the other axis.

Figure 2. Province of Newfoundland and Labrador Framework for the Development of a Provincial Mental Health Policy

Quadrant 1:	People have good mental health and no mental illness
Quadrant 2:	People may have severe stresses on their mental health but do not have a mental illness
Quadrant 3:	People may have mental illnesses but still have good mental health. With a secure income, strong support from family and friends, a home and a job to return to after episodes of illness, a person may cope well with the challenge of having a mental illness
Quadrant 4:	People have mental illnesses and also severe stress on their mental health. They may be unemployed, living in poverty and poor housing, with little family or social support. They may experience stigma and discrimination and have little access to education and satisfying work opportunities. Quadrant 4 represents the people with the greatest needs for both mental health services and community support.

(Province of Newfoundland and Labrador, 2001, p. 5)

The four resulting quadrants that developed between the two axes are defined in Figure 2.

The dual axis models of Saskatchewan and the province of Newfoundland and Labrador fundamentally reflects knowledge that, while promotion and maintenance of mental health is necessary, so is direct treatment intervention for persons who experience mental illness. While practitioners of both the clinico-medical model and the population health approach recognize the importance of both axes, each might tend to focus more on one axis at the expense of the other. Nevertheless, both are important and central to people in the province of Saskatchewan.

Defining Mental Health

Satisfactory definitions of mental health remain elusive. Both the World Health Organization and the United States Surgeon General have pointed out that definitions of mental health are culture-bound and express the values systems of the people doing the defining, stating that "what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures" (Surgeon General, 2001).

The World Health Organization takes more of an epidemiological, public-health approach to mental health and recognizes mental health on a continuum of individual healthiness, extending from health to illness, with "mental problems" in the middle (WHO, 2001). The Surgeon General (2001) offered the following definition of mental health:

> The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem.

While this definition is laudable, it does not situate individual health within the context of larger health determinants and social conditions. Within the population health approach, mental health is thought of as capacity and resource, suggesting that a person's ability to achieve mental health is a function of multiple factors, not just their own "performance" of mental function, which seems to make the individual person predominantly or even exclusively responsible for the achievement of mental health.

It might be possible to revise the above definition and refer to mental health as *the capacity of a person to engage in* productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem.

The Canadian Department of National Health and Welfare built the idea of "capacity" into its 1988 definition of mental health, defining it as follows (p. 7):

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and relations), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Citing "equitability in distribution and exercise of power" as a "crucial factor in mental health," the Canadian definition builds the social values of human equality, social responsibility, justice, and freedom of choice into its definition of mental health in an attempt to illustrate the individual, social, and legal aspects of human health and interaction within a Canadian societal perspective. Therefore, the Canadian definition of mental health gives attention to mental health as involving, in part, healthy living according to the capacity of the individual in the context of the collective values and goals of Canadian society. Saskatchewan's Mental Health Services Branch (1990) adopted this Canadian definition of mental health as part of its *Core Services* document.

While both the American Surgeon General's and the Canadian Department of National Health and Welfare's definitions may seem comprehensive, neither definition is sensitive to the developmental needs and vulnerabilities of children and youth. In thinking about how to define mental health for children and adolescents, it might be beneficial to think about the capacity of a child or adolescent to engage not so much in "productive activities" as in activities of normal development.

Accordingly, mental health for a child or adolescent could be seen for purposes of this report as

> *the capacity of a child or adolescent to meet culturally normative developmental milestones by engaging in activities of normal development,* fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem.

Whether the person's mental health should be defined in terms of the achievement of societal goals consistent with justice and the attainment of fundamental equality seems more of a political and philosophical question and may involve conflicting views of a person's rights and sense of civil liberty. The definition risks the identification of people who do not work for collective goals in society as not being mentally well or not having the capacity for mental health. Some definitions of mental health are more socially or normatively based; however, Canadian definitions of mental health need to take into account the very great number of cultural groups in the country and reflect the idea that persons from different cultures may work in different ways to meet both individual and collective goals. Therefore, the idea of societal goals has been left out of the working definition of mental health for this report.

Viewing child and adolescent mental health in terms of capacity, resources, and determinants of both health and illness advances our understanding of children and adolescents as young people who bring personal strengths and weaknesses that may be enhanced or blocked by the structures, services, socioeconomic conditions, history, and future plans of Saskatchewan and Canadian society.

Part 4
Best Practices in Child and Adolescent Mental Health in Saskatchewan

Understanding best practices relative to fostering mental health and addressing service-delivery systems requires a systematic approach to inquiry. Although a number of approaches are possible, this report is organized according to the eight key elements Health Canada (2002) has identified as important to consider when attempting to reduce inequities in health status and improve the general health status of the population. Although these eight elements derive from a population health perspective, they also encompass the mental illness axis. In fact, in addressing the eight key elements, significant time was spent considering the mental illness axis, as it has been the primary focus of mental health care delivery for children and families for a long time. Health Canada's eight key elements are as follows:

1. focus on the health of populations
2. address the determinants of health and their interactions
3. base decisions on evidence
4. increase upstream investments
5. apply multiple strategies
6. collaborate across sectors and levels
7. employ mechanisms for public involvement
8. demonstrate accountability for health outcomes

These eight elements will guide the ensuing discussion of issues important in mental health status and service delivery in Saskatchewan.

1. Focusing on the Mental Health of Children and Adolescents

The Sub-Committee on Self-Regulating Systems for the Federal/Provincial/Territorial Working Group on the Mental Health and Well-being of Children and Youth (2000) reported to Health Canada that a dearth of research exists on key indicators of mental health in Canada. The sub-committee also pointed out a dearth of research on appropriate knowledge regarding rewards and incentives for activities designed to improve health and well-being. The same is true for Saskatchewan.

Adequate measurement of mental health status, inequities, and contextual conditions remains impossible without adequate research on the key mental health indicators for children and adolescents in our province. However, opportunities for research on children's mental health have been limited in this province by a number of important factors.

First, Saskatchewan has an extreme shortage of clinicians and researchers who are trained and practice in the area of child and adolescent mental health (Conway, 2003). Saskatchewan has had a history of severe problems attracting and retaining both clinicians and researchers. According to Conway (2003), Saskatchewan has approximately one-half the per capita number of clinical psychologists and one-third the per capita number of psychiatrists as compared with the national average in Canada.

Part of the problem may relate to difficulties in attracting people from outside Saskatchewan to the geographical climate of the province, as indicated in the MacDonald Task Force report. However, other issues that are also of significance include historically low provincial priorities for support of research in terms of both funding and capital expenditures for space and equipment. Without adequate infrastructure development for research, universities have difficulty attracting personnel to work in the province. This problem is compounded by the fact that, in the current academic climate, provincial universities tend not to hire their own graduates. MacDonald (1983) and Conway (2003) both pointed to the difficulties in attracting and retaining personnel, and there is no empirical evidence demonstrating that recent doctoral graduates from outside the province perform better or any differently from those trained inside the province.

Research on Saskatchewan children and adolescents also depends on support for research in the province, as well as a critical mass of qualified researchers and clinicians who are interconnected with each other. In addition to problems of research infrastructure and personnel, there is a general, pervasive separation between research and clinical personnel in the province, with researchers and clinicians rarely collaborating with each other to produce research that would be relevant to strengthening our provincial mental health systems. More collaboration between these two streams would benefit everyone in the context of a provincial strategy for attracting and/or retaining researchers and research funding. Collaboration would also provide opportunities for clinicians to modify their workload and become involved in projects that are professionally stimulating and enriching for their clinical work, thereby enhancing the professional development of clinicians, which MacDonald identified as an ongoing concern.

Goal orientation in child and adolescent mental health can take a number of different focuses, including being directed towards scientific discovery, optimization/ treatment, or clinical training. All of these goals are important and necessary to having a strong mental health system in place.

However, interconnections between people having these different kinds of focus would enable key indicators of mental health for the province to be better identified. Communication of research findings to policy-makers is also necessary, to enable provincially coordinated efforts to bring about optimal levels of mental health and lower levels of mental illness in the province.

The recently formed Saskatchewan Academic Health Sciences Network has released a vision document discussing "strategic priorities to advance the attainment of" what they describe as a "preferred but realistic future for academic health sciences" in Saskatchewan (2003, p. 2). The Network is a partnership primarily between the University of Saskatchewan, the Saskatoon Health Region, the Regina Qu'Appelle Health Region, as well as the provincial departments of Health and Learning. "Focus on Provincial Needs" forms a part of the network's strategic priorities; however, the main emphasis will be on "primary health, Aboriginal health, and rural needs." Although one member of the Clinical Psychology program at the University of Saskatchewan sat on the planning team, mental health was not established as a clear priority in the document, nor were child and adolescent services. Although the province trains clinical psychologists and psychiatrists, no program has made the training of child and adolescent clinicians a specific program priority.

2. Addressing the Determinants of Health for Children and Adolescents

It is difficult to track determinants of health in relation to mental health statistics, and this generally has not been a primary focus in Saskatchewan. Typically, mental illness statistics are tracked instead, often according to general or psychiatric hospital admissions. For example, in the 2001 *Saskatchewan Mental Health Program Review* by the Community Care Branch of Saskatchewan Health, statistics were reported by diagnosis for physician-delivered services only, including general practitioners, other specialties, and psychiatrists but not for clinical psychologists, social workers or other allied health professionals.

Also, statistics for hospital-based services were focused on in the review, but these can be misleading for a number of reasons. First, only the more severe cases would be cause for hospital admission, putting the spotlight on a small number of severe cases rather than the greater number of mental health problems experienced by children and youth that would not require hospitalization. Second, hospital admission statistics do not reflect problems of under-use of services by some population groups. Third, hospital admission statistics do not address the large number of people treated for mental health problems via private counselling services or community-based, family physicians.

Finally, hospital admissions can only address a small number of cases overall, given the limited capacity of inpatient units to address child and youth mental health problems.

Saskatchewan does not have an adequate system for tracking the prevalence of mental disorders for children and adolescents in the province, as well as the proportion of children and adolescents who access mental health interventions for their problems. In an effort to develop a better estimate of the prevalence of mental disorders in children and youth in British Columbia, Waddell and Shepherd (2002) reviewed a number of studies that had been performed, including the *Ontario Child Health Study*. They determined that the prevalence rate for having any mental disorder for children and youth was 15%. This is higher than Statistics Canada's recently released rate of 10% for mental health problems in Canadians aged 15 years and up during a one-year period. According to Waddell and Shepherd (2002), the *Ontario Child Health Study* reported the following rates for child mental health problems: anxiety disorders (6.5%), conduct disorder (3.3%), attention deficit/ hyperactivity disorder (3.3%), any depressive disorder (2.1%), with remaining categories under 1%. Waddell and Shepherd applied these percentages to the British Columbia population to determine the estimated rates for their province.

Waddell and Shepherd's (2002) prevalence rates could be applied, hypothetically, to Saskatchewan. This could be done only with the understanding that Saskatchewan has a higher-than-average proportion of First Nations youth who have unique vulnerabilities as compared with the general population.[1]

Figure 3. Comparison of the Saskatchewan Child/Adolescent Population with the Estimated Need for Mental Health Services

Age Group	2003 Saskatchewan Covered Population	Estimate of Need for Mental Health Services (15%)
<1	11,596	1,739
1-4	49,091	7,374
5-9	66,863	10,029
10-14	76,521	11,478
15-19	79,181	11,877
Total	**283,252**	**42,488**

Source: Saskatchewan Health, 2003 Covered Population.

The 2003 population of Saskatchewan was 1,007,753 persons (Saskatchewan Health, 2003 Covered Population, retrieved from http://www.health.gov.sk.ca/mc_dp_covpop2003/CovPopBook2003.pdf). The population of children and adolescents in Saskatchewan 19 years of age and under is 283,252 or 28% of the total population.

[1] One could argue that Saskatchewan's First Nations population could be counter-balanced in the statistics by British Columbia's higher immigrant population. However, new immigrant children in Canada have been shown to have lower overall rates of mental health problems than the national average in Canada (Beiser, Hou, Hyman, & Tousignant, 1998). In addition, given that First Nations peoples in Canada are not immigrants, these two groups could not be substituted for each other in statistical comparisons.

Figure 3 provides an estimate of the need for mental health services in Saskatchewan using Waddell and Shepherd's (2002) example of prevalence rates and the 2003 provincial covered population numbers. According to Waddell and Shepherd's (2002) example, if 15% of young persons in the province have a mental disorder, 42,488 young people under the age 20 years would be estimated to be in need of mental health services in Saskatchewan.

When there is No Emergency Resource

In one extraordinary circumstance, a secure custody facility for young offenders was utilized as an emergency mental health stabilization resource for a young person when he threatened suicide and engaged in other high-risk behaviors. This young person, who was a child in care under *The Child and Family Services Act* was not involved in any criminal activity but when the mental health unit determined that he did not meet the admission criteria, his parents and the group home staff arranged to have him placed in the secure custody facility in order to keep him safe from harming himself or others. Saskatchewan government officials acknowledged that the use of this resource was not legislatively authorized and that there was a lack of appropriate residential or therapeutic resources for youth. This young person was subsequently placed in a long-term residential treatment program. The Children's Advocate Office recommended that measures be taken to ensure that, in the future, young people are not inappropriately placed in facilities designated for youth secure custody. This recommendation was accepted.

Knowing how many children and youth require mental health services is not the same as knowing how many of those children and adolescents are actually able to access those services. In a cross-national study of the prevalence and treatment of mental health and substance use disorders, Bjil, de Graaf, Hiripi, et al. (2003) found some of the lowest rates for mental health treatment in Canada, as compared with the United States, the Netherlands, Germany, and Chile. The authors speculated that low treatment rates in Canada were due to a combination of factors, including general Canadian reluctance to seek treatment for minor problems as well as the existence of high barriers to mental health treatment access in the Canadian health-care system.

According to Saskatchewan Health, mental health services, as provided through the regional health authorities, treat 4,500 children and adolescents annually, which represents only 10% of the 42,488 children and adolescents estimated to have a mental disorder.

In Ontario, Peters, Lafreniere, and Digout (2001) found that less than 20% of children and adolescents between the ages of 4-16 who have one or more serious behavioural or emotional disorders are accessing those services (p. 4). It is difficult to directly compare Ontario to Saskatchewan because population age statistic categories are not reported according to the same breakdowns.

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It has been virtually impossible to ascertain the actual level of mental health services delivered as there are many other mental health services provided through other health sectors (e.g. family physicians), departments (e.g. Community Resources and Employment, Saskatchewan Learning) and agencies (e.g. employee and family assistance programs).

In addition to consideration for the prevalence of mental disorders, an understanding of mental health in Saskatchewan children and adolescents requires an understanding of those environmental determinants that may have a significant impact on the capacity of a child and family to achieve well-being. Based on data from the Canadian Institute of Child Health (2000; Retrieved from http://www.cich.ca/PDFFiles/ProfileFactSheets/ English/ ProvSaskatchewanENG.pdf), Saskatchewan has a number of special environmental determinants that might be taken into consideration when planning mental health services and health promotion programs for children and youth. For example, Saskatchewan has a greater rural population than the national average, as well as a significantly higher population of persons having First Nations ancestry (11%), as compared with a Canadian national average (2.8%). A greater percentage (28%) of the Saskatchewan population is under the age of 20, as compared with the Canadian national average (27%). These and other determinants of health have both direct and indirect relationships to the current and future mental health/mental illness of Saskatchewan's children, adolescents, and families.

Other determinants of health affecting both health promotion and service delivery in Saskatchewan are worth noting. For example, Saskatchewan appears to have the same percentage of single-parent homes as compared with other provinces, but the teen pregnancy rate tends to be higher than that of other provinces, at 63 out of every 1000 births. Saskatchewan has a higher infant mortality rate (9:1000) than the Canadian average (6:1000), and Saskatchewan's death rate in the 1 to 4-year-old and 5 to 9-year- old age groupings is two times the Canadian national average. In addition, to meet Canadian national standards for poverty-line living, in Saskatchewan a single parent with one child would have to work a 63-hour work week at the current minimum wage. In terms of income support through income security programs, a single parent with one child in Saskatchewan would be living at only 58% of the level of income set as the Canadian poverty-line. According to the *Saskatchewan Child Poverty Report* (Faculty of Social Work Regina, November 2003), Saskatchewan's child poverty rate stood at 17.6%, which is higher than the national rate of 15.6%.

Finally, in terms of parenting support, as of December 31, 2003 there were 7,610 licensed daycare centres and family childcare homes in Saskatchewan (Child Day Care Branch, Saskatchewan Community Resources and Employment, 2004). These regulated child-care spaces could accommodate only 12% of the children in the province, age 4 and younger. In addition, the province has a higher need for subsidized spaces due to provincial rates of low-income.

As an alternative to formal childcare or staying at home, Canadian parents increasingly are finding electronic means (cell phones, beepers) by which to keep in touch with their children (Higgins & Duxbury, 2001). According to Health Canada's *2001 National Work-Life Conflict Study: Report One* (Higgins & Duxbury, 2001; Retrieved from http://www.hcsc.gc.ca/pphb-dgspsp/publicat/work-travail/#exec), Canadian workers have reported finding it difficult to balance work expectations and hours with meeting the needs of their families. Higgins and Duxbury reported that this is particularly the case for men, managers and professionals of both genders, and employees in the not-for-profit sector. Targeted research and tracking of special vulnerabilities experienced by Saskatchewan children and youth in relation to determinants of health and access to mental health services will assist governments, universities, as well as mental health professionals in establishing policies and initiatives for addressing the mental health needs of young people in the province.

3. Evidence-based Practice for Child and Adolescent Mental Health

Recently, Conway (2003) released a report on the Saskatchewan Mental Health Sector discussing from whom provincial residents receive mental health care. In that report, he identified evidence-based treatment programs as an area of concern for Saskatchewan mental health service delivery and cited a few areas in which evidence-based psychological treatments exist for children and adolescents (e.g., behavioral programs for ADHD, disruptive disorders, anxiety disorders; multi-systemic therapy for antisocial adolescents).

However, Hoagwood, Burns, Kiser, Ringelsen, and Schoenwald (2001) published an extended discussion of issues in evidence-based practice for child and adolescent mental health services. They pointed out that, although "the term 'evidence-based' has an almost intuitive ring of credibility to it" (p. 1179), the idea of evidence-based practice has very different implications for children's mental health services than for adult mental health services.

Hoagwood, Burns, Kiser, Ringelsen, and Schoenwald (2001) noted that rapidity of developmental change must be taken into account when assessing the effectiveness of a treatment approach for children. In addition, they highlighted the fact that significant differences also may occur between what is efficacious for *children as compared with what works for adolescents. Therefore, age-related* change must be considered along with the developmental conditions that may have an impact on the sustainability of treatment effects.

Taking more of a dynamic systems approach to child development, Hoagwood, Burns, Kiser, Ringelsen, and Schoenwald (2001) also focused on the context of treatment services to children and adolescents, commenting that attention must be paid to "the complex and dynamic interactions among the child, the family, and the environmental context that accompany maturation" (p. 1181). They maintain that diagnostic meaning is tied to context such that involvement of caregivers is central to understanding the conceptualization of the mental health problem as well as implementing the actual treatment services to children and adolescents.

In addition, Hoagwood, Burns, Kiser, Ringelsen, and Schoenwald (2001) discussed the fact that service delivery to children occurs across a broad range of therapeutic venues, including schools, clinics, correctional facilities, child protection systems, or primary healthcare settings, among others. Given the broad range of venues, a large variety of mental health personnel would need to be trained in evidence-based treatments across a variety of mandates and professions. The broad range of venues and personnel poses another problem for claims of evidence-based practice in that laboratory-based findings of treatment efficacy might not transfer across all of those different contexts for service delivery.

Hoagwood, Burns, Kiser, Ringelsen, and Schoenwald (2001) were not arguing against the necessity of evidence-based treatments; they were trying to demonstrate that finding a treatment to be efficacious based on principles of "evidence-based practice" likely will not have the same force of meaning across all developmental levels and multiple contexts of treatment delivery for children and adolescents. Therefore, evidence-based practice, while desirable, requires special considerations and a greater complexity of research design than is typically acknowledged by proponents of it.

For example, the University at Buffalo has been sponsoring a biennial conference on evidence-based treatments for childhood and adolescent mental health. The conference recently had its third series. Therefore, although little has occurred overall in terms of evidence-based practice for child and adolescent mental health, some new growth has begun to bud in this area.

4. Investing Upstream for Child and Adolescent Mental Health

One way that Health Canada has attempted to address problems relating to determinants of health is to recommend investing upstream relative to those problems, which essentially means investing in early intervention and prevention programs. With regard to the mental health of children and youth, this could mean a breadth of program initiatives, including those as various as Head Start or other preschool interventions, prenatal care programs for high risk mothers, changing minimum wage levels, funding psycho-educational programs for youth, or altering families' access to more daycare spaces.

Examples of population-based prevention programs that have been effective include home-visiting programs, high-quality early childcare and education, prenatal programs, school-based programs, well-supervised recreational activities, and intervention targeted at the medical and social needs of mothers and children on income security programs (Steinhauer, 1999). The ideas for how to address important determinants of health may seem quite limitless; however, they should be guided by empirical research on what determinants of health are most significant for children and youth in the province and where the province might be particularly weak relative to these determinants. Peters, Lafreniere, and Digout (2001) noted that few well-designed and published studies exist which evaluate the effectiveness of prevention programs in Canada, despite these programs' recent increase in popularity.

5. Applying Multiple Strategies in Addressing Child and Adolescent Mental Health

Certainly, no one approach to mental health development could address all needs and problems which children, adolescents, and their families encounter. Attempts to address and improve population health determinants across a broad spectrum of social concerns are necessary and integral to the optimization of mental health for people in the province. However, at some point, the specific details of service delivery from mental health interventions must also be addressed. One overarching conclusion appears clear in the psychological literature: Mental health services to children and adolescents must become less fragmented and more coordinated/integrated across government departments and service-delivery agencies. To support this kind of coordination and integration, Saskatchewan might need to consider how to develop a socialization model for team building amongst personnel in targeted key areas.

This section of the document will explore four strategies for addressing child and adolescent mental health service delivery: (1) integration of mental health services with primary health care; (2) integration of services with schools; (3) family involvement in the mental health system; (4) integrated case management and other collaborative models.

I. Integration with Primary Health Care

Recently, the British Columbia Psychological Association (BCPA, 2003) put forward a proposal for broader use of psychologists within the health care system. Recognizing that the greatest amount of funding was being directed to the most severe problems, BCPA has proposed that better integration of psychologists into the healthcare system would provide funded access to mental health services for the majority of people who have less severe and more common kinds of mental health problems without increasing the overall financial burden to the province. Integration of qualified mental health workers into the mainstream of primary health services has been shown to be an effective and less stigmatizing vehicle for service delivery (Wagenfeld, Murray, Mohatt, & DeBruyn, 1997). This may be one way in which rural mental health care services could provide for better, more confidential access to mental health resources right in rural communities.

II. Integration with Schools

Over the past number of years, child and adolescent mental health services have been structured with a primary focus on individualized treatment programs delivered through standard clinic-based programs which seem stretched to their capacity now and have been for quite some time. However, mental health clinic-based interventions are not the only service-delivery setting in which to address the mental health problems of children, youth, and their families.

When the School System Does Not Meet the Needs

Children with mental health problems may also have difficulty managing their behavior at school. Parents call the Children's Advocate Office with concerns about decisions schools have made about their children. For example, one mother called us when her son was suspended from school for three weeks due to his behavior. The school decided that her son could not attend school if he was not given Ritalin medication. Several other parents have called the Children's Advocate Office also concerned that their children are not being allowed to attend school if they are not taking medication, including children with special needs.

In both the research and policy areas, there has been a surge of interest across North America in addressing mental health problems through a variety of venues, the most popular of which seems to be the educational system. Part of this drive stems from the recognition that children spend a great deal of time at school; therefore, accessing children at school seems both logical and convenient. Schools also constitute a natural hub for collaboration and information sharing across a variety of agencies and sectors. Schools provide a unique vehicle through which children's and adolescents' mental health problems may be addressed.

In addition, schools provide a primary avenue through which multiple determinants of health can be both monitored and fortified on a community-wide basis.

However, the question arises regarding *who* at the school would be responsible for addressing mental health issues for students. Teachers are on the front line in terms of being able to identify obvious mental health problems in children, such as severe behavioral acting out. Yet, teachers cannot be expected, given their job mandates and their training, to engage in mental health treatment. Teachers are, nevertheless, important partners in helping students to adjust personally and socially and are integral to intervention and prevention programs for youth at the community level (Poduska, 2000).

The National Association of School Psychologists (NASP) issued a statement regarding mental health services in schools. In this statement, they offered clear support and advocacy for the presence of psychologists, counselors, and social workers within schools as a first priority. The Minnesota Department of Children, Families, and Learning has also been proactively supporting students' access to mental health services within their schools by publishing a manual in order to assist educators in planning programs and delivering service to students with mental health problems. By addressing the mental health needs of their students directly, the Minnesota Department is attempting to decrease their high level of expenditure on indirect services related to students' mental health problems, including one-on-one behavioral supervision, high-cost behavioral programming, and highly restrictive programs. NASP cited psychologist-to-student ratios as being greater than 1:2,500. Although statistics for this have not been obtained regarding Saskatchewan school divisions, the ratios likely are not very different or may be even more disparate, with greater numbers of students being served by fewer registered psychologists. Services presently provided by psychologists through the school system tend to be limited to psychoeducational assessment and behavioral consultation, with other mental health problems being handled outside of the school system.

In addition, NASP (2002) discussed opportunities for building on child and youth *capacity* for mental health in a number of ways. First, they recommended building protective factors into the school environment by helping children to develop a sense of belonging, adaptation to change, recognition through positive feedback, and opportunity for social input. NASP also mentioned the importance of fostering resiliency and a sense of accomplishment in children and youth through a focus on strengthening their self-efficacy and self-determination within the school community.

Next, NASP discussed the ability of schools to address mental health problems by creating a supportive school climate, implementing mental health programs within the school, and providing individual intervention to students with mental health problems.

NASP also identified the importance of educators knowing the signs of mental health problems, helping students to access help, and liaising with school-based mental health workers in an effort to support students in their attempts to foster mental well-being.

School-based clinics are one way in which individual intervention can be delivered in order to address concerns regarding mental disorders as well as other kinds of life-stressors. These clinics tend to be focused initially or primarily on physical health, but, in their practice have broadened focus to mental health concerns. These clinics exist within schools but are not run by school personnel. The nature of the clinic's operation is important to consider, especially for reasons of privacy and confidentiality.

Combining health, mental health, and school records or blurring access to these documents creates a risk for violation of a child's, adolescent's, or family's confidentiality. Ordinarily, only persons who are directly involved with a person in need of health or mental health intervention have routine access to the person's health records. Even within some hospital systems, access restrictions are established which result in mental health records being held separately from physical health records so that mental health records are not viewed by personnel who do not require access to them.

Therefore, procedures would need to be established so that education records and health/mental health records are viewed only by personnel directly working with children and adolescents in the school-based clinic, with information being shared on a need-to-know basis in keeping with established procedures for ensuring confidentiality.

Schwalberg and Hill (1995) pointed out that adolescents prefer using school-based services and centres designed to meet specifically adolescent needs because of their concern for "confidentiality, short waits for appointments, and convenient locations and hours of operation" (p. 1). In addition, they noted the importance of delivering services to adolescents in settings where teens feel comfortable. As of 1995, Schwalberg and Hill reported the existence of 600 school-based clinics across 42 American states.

Harold and Harold (1993) found that school-based clinics, while initially focused primarily on reproductive health issues, were effective in addressing a broad range of physical and mental health needs for adolescents. Harold and Harold found that adolescents were less likely to access health and mental health services that were located in unfamiliar settings, but that they were more likely to access these services when they were located in the school. They also found that school-based clinics were acceptable to students, due to the clinics' being adolescent-focused, being viewed as safe havens, and providing comprehensive services. The clinics also contributed to a supportive climate in the school and enabled staff to identify relationships between adolescents' problems in school and other psychosocial problems in their lives.

When the School System Does Not Meet the Needs

A parent of a 14 -year-old with Attention Deficit Hyperactivity Disorder was told that their son would not be allowed to attend school for the full year if the parents didn't obtain a psychological assessment for their son by September 30th. In addition, the parents learned that it would take about six months before the assessment would be completed, making it impossible for their son to attend school that year. The Children's Advocate Office provided advice to these parents about how to access the mediation provisions in *The Education Act*.

Creating supportive school climates also tends to increase students' engagement and interest in learning, which tends to be a pervasive problem particularly during the adolescent years (Steinberg, 1996).

In a study of mental health and special education collaboration, Babyak and Koorland (2001) identified a number of positive outcomes that collaboration between mental health professionals and teachers offered, including direct service provision, assessment and evaluation reports, service coordination and referral. Indirect services such as consulting, providing general support, as well as developing, modeling, and monitoring intervention programs for students were also identified as positive outcomes. Waxman, Weist, and Benson (1999) found similar results in their study of collaboration between educators and mental health workers.

Babyak and Koorland (2001) also identified a number of difficulties and barriers to collaboration between mental health professionals and educators. First, differences in philosophies and beliefs, as well as role confusion, resulted in poor team-work and lack of communication/collaboration. Second, a shortage of mental health professionals, inappropriate use of mental health professionals, and lack of personnel consistency were cited as examples of problems with resources. Third, some pragmatic barriers arose, including difficulties with scheduling, lack of consultation time, lack of adherence to school policies by mental health professionals, lack of knowledge about educational law, and use of discipline-specific jargon by both groups.

While the benefits of having mental health professionals working with educators and students were apparent in the Babyak and Koorland (2001) study, collaboration required improvements in the areas of communication, service provision, and practice knowledge. In addition, mutual understanding and empathy for the workloads of both the mental health professionals and the teachers were required in order for effective collaboration to occur. Waxman, Weist, and Benson (1999) concluded that, although collaborative teams were helpful, putting together this kind of team was formidable and rarely ever happened.

When the School System Does Not Meet the Needs

A family reported to the Children's Advocate Office that they withdrew their autistic son from school when the school refused to discontinue using force to remove him from the classroom to a "time out room." Attempts to mediate this conflict were not successful, although the child did return to school.

In an address at the annual meeting of the Ontario Association of Children's Mental Health Centres, Paul Steinhauer (1999; Retrieved from http://www.sparrowlake.org/publications/papers.htm#MentalHealthServices) pointed out that the use of a mental health consultation model works in children's mental health services and benefits both education and mental health professionals. He maintained that collaboration provided insight for both parties into the concerns, workload, and perspectives of each others' disciplines and provided opportunity for effective sharing of knowledge in both directions. In other words, it made better professionals out of both the educators and the mental health workers because it was "a reciprocal learning experience" (Steinhauer, 1999).

Recently, the Saskatchewan government initiated a task force on the role of the school, chaired by Michael Tymchak. The Tymchak report (Tymchak & Saskatchewan Instructional Development and Research Unit, 2001) presented an initiative called School^{Plus}, a vision for educational service delivery to children and adolescents. Fundamentally, the task force challenged the Saskatchewan government to consider an innovative approach to development of school facilities and educational service delivery that is integrative across a broad spectrum of services from both the public and private sectors and that would have a significant impact on school climate in Saskatchewan.

In terms of mental health services, the task force made eight important recommendations designed to create a school environment that integrated service delivery across health, social services, justice, and education. Their recommendations in this regard were as follows (quoted from Tymchak and Saskatchewan Instructional Development and Research Unit, 2001, pp. 116-117):

1. That the Government of Saskatchewan authorize the principle that all services to children and youth in the province shall be delivered in a truly integrated environment that is school-linked and, where possible and feasible, school-based.
2. That Cabinet instruct senior officials from all of the human service agencies, including Health, Social Services, Justice and Education, to meet and determine appropriate procedures for the coordination of future budget submissions from their departments relating to children and youth, so as to best support the integrated services model represented by School^{Plus}.
3. That Cabinet instruct its senior officials from the above-mentioned human service departments to consider what sort of administrative arrangements and mechanisms might best support the assignment of staff from any agency to the School^{Plus} environment.
4. That the Interagency Fund be used, in part, to support the creation of School^{Plus}.

5. That the Saskatchewan School Trustees Association (SSTA), Saskatchewan Teachers' Federation (STF), League of Educational Administrators, Directors and Superintendents (LEADS), and Saskatchewan Education explore the implications of the differentiated staffing environment entailed by School^{Plus}. Further, it is proposed that Saskatchewan Education take the lead in calling the first meeting to discuss the most appropriate mechanism and process for addressing these issues and questions.

6. That the SSTA, STF, LEADS and Saskatchewan Education explore the organizational and legal implications of creating the integrated services environment suggested by School^{Plus}, including governance, supervision, liability and legislation.

7. That a broad-based interagency group, including the Human Services Integration Forum (HSIF), and representatives from SSTA, STF, and LEADS be convened to consider the creation of an authorized, truly integrated human services environment that is articulated with public education and is focused on the needs of children and youth (earlier we called this environment the Saskatchewan Education and Human Services Network – SEAHSN).

8. That the Saskatchewan Teachers' Federation give consideration to creating a Special Subject Council for the purpose of addressing issues pertaining to "Community Schools/ School^{Plus}.

The School^{Plus} initiative was adopted by the Saskatchewan government as a long-term commitment in a provincial response (Government of Saskatchewan, 2002) signed by the ministers of the Departments of Education, Social Services, Justice, Aboriginal Affairs, Intergovernmental Affairs, Post-Secondary Education and Skills Training, Health, as well as the Department of Culture, Youth, and Recreation. The creators of the School^{Plus} initiative recognized the importance of correcting interagency service fragmentation and improving coordination in services to children and adolescents, while simultaneously improving on the climate of schools in the province.

Extensive consultation across a number of provincial departments, agencies, networks, and professional associations was recommended in the School^{Plus} report. However, genuine collaboration, not just consultation, with the professional associations and labour groups of the human service agencies outside of the educational field likely will also be necessary if professionals from those disciplines are to be integrated into the School^{Plus} program successfully in either clinical or consultative roles.

However, creation of an integrated system for mental health service delivery within the school system, as the Tymchak report recommended, to be transparent must also be open to external investigation and review. For example, at the present time, the Children's Advocate Office does not have the legislative authority to investigate school-related complaints. In addition, parents might be described as having relatively little authority over what happens to their children within the provincial schools.

Furthermore, equal partnering in terms of system development and "ownership" would need to be developed between all stakeholders so that the system does not come exclusively under the authority of the school system.

III. Family Involvement

Although children and youth sometimes have highly individual, even biologicallybased mental health problems, their problems always occur within the context of the family, no matter what the problem's primary etiology. Involvement of the child's family, whenever appropriate, in the assessment, planning, intervention, and evaluation of services is essential and of primary consideration when funding for child and youth mental health is being determined.

When Parents Separate

Accessing mental health services for children or youth when parents are in the process of a marital separation or divorce has repeatedly been raised as an issue by parents with the CAO. In one situation, the boy had a history of mental health problems and was receiving counselling prior to his parents' separation. The mother was advised that her son's counselling would be terminated until after the parent's court proceedings and divorce were settled, as the mother understood that it was the mental health policy to suspend counselling when parents are in a custody or access dispute. Saskatchewan Health advised the Children's Advocate Office that each child's situation is reviewed individually and if the mental health concern is not considered urgent, then counselling may be delayed while the unresolved custody and access matters are attended to, especially where the parents' lack of cooperation seriously impairs their child's progress in counselling. Furthermore, Saskatchewan Health reassured the CAO that all efforts are made to see that other services and supports are in place, or continue for the child, and that counselling is resumed when it is likely to be of benefit to the child. Each child's case is reviewed in terms of the impact on the child and there is no policy to discontinue mental health services in all of these cases. This family decided to obtain the services of a private counselor for their son. On closing this matter, the mother told the Children's Advocate Office that she "feels that the children and youth are the ones to suffer and especially need support during this period of time." She also said that she "disagreed with the way the system handles this and feels fortunate that she was able to secure a private counselor for her son."

In a study of parental perceptions of the mental health and educational services needs of their first-grade children, Poduska (2000) found that 39% of children were perceived as needing services. Parental perception of need for service must be considered in relation to the provincial base-rate for the occurrence of disorders, as well as the province's vision for meeting the mental health and illness needs for children and youth. Nevertheless, to be respectful of families' rights and wishes, Poduska recommended that children's access to mental health services involve a process for parental consent as well as systematic parental participation in the full decision-making process by which services to children are determined (Poduska, 2000). Poduska recommended least-restrictive services as well as prevention programs to address, in the broadest way, children's problems of a more common and less severe nature.

However, for those children who do not respond to general and preventive programming, individualized services with parental involvement was recommended. Clearly, all services must balance the safety and rights of children with the rights and wishes of their families.

Osher and Osher (2002) pointed out that moving service delivery systems to family-based intervention involves a paradigm shift in order to achieve full collaborative partnerships between professionals and families. The paradigm shift fundamentally constituted movement from a provider-driven, intervention-based system to a family-driven model that had as its orientation "enabling the child and family to do better in the community" (Osher & Osher, 2002, p. 52). Fundamentally, Osher and Osher described a shift from the clinico-medical model to a partnership model in greater keeping with a strengths-based approach to intervention, as well as recognition of the multiple determinants of health that affect child, adolescent, and family functioning over time. According to Osher and Osher, a family-based model also requires professionals to be competent to work with the culture of a family.

Osher and Osher also made a strong distinction between family-focused services and family-driven services. Drawing on the history of the 1980's system-of-care and 1990's wrap-around approaches to children's mental health, Osher and Osher criticized these early models for failing to identify the difference between family-driven services and family-focused services, the latter of the two remaining a form of provider-based intervention that created little motivation and low expectations for families to change. A family-driven model, according to Osher and Osher (2002), assumes that families will take a leadership role in planning for their children and are experts in their children's needs, strengths, and weaknesses. Although they can be bolstered in their planning by professionals, who are there to provide information and direction, families fundamentally work from the same information that the professionals have, with transparent sharing of information in both directions. However, service providers also outline firm expectations for families' compliance with intervention goals, as determined collaboratively by the family and the professionals, as well as specific behavioural standards for achieving goals. Osher and Osher (pp. 55-56) noted that

> [w]hen providers recognize child and family strengths and value their experience and when planning proceeds in a manner that is congruent with the family's desires and ability, commitment by everyone on the team to implementing the plan is high. In addition, since outcome evaluation is an ongoing process, the team has the opportunity to frequently assess the effectiveness of the interventions and make adjustments as necessary to achieve a better outcome.

Osher and Osher also identified a number of model programs in operation as well as several factors necessary for these kinds of programs to be successful.

IV. Integrated Case Management and Other Collaborative Models

In order to develop strong systems of care, agencies need to collaborate across a number of systems, disciplines, and administrative structures. In their development of a multi-agency integrated system of care, the Center for Mental Health Services in Santa Barbara County, California identified five best-practice service delivery procedures, as follows (quoted from Woodbridge, Furlong, Casas, and Sosna, 2001, p. 63):

1. co-location of interagency staff
2. a precision-of-fit delivery system
3. comprehensive assessment procedures
4. interagency database integration
5. systematic outcomes-based management

Development of these practices requires a strategic plan, a high level of cooperation, and allocation of resources to address key areas of change to enable smooth transitions. Such change cannot occur without guidelines for how children's mental health services should be delivered. The Bazelon Center for Mental Health Law (2001) recommended 12 principles for delivery of children's mental health services:

1. collaboration with the child and family
2. a focus on functional outcomes for children
3. collaboration with others in multi-agency, multi-system service teams
4. accessibility of services
5. best practices provided by adequately trained and supervised individuals, who focus on identification and appropriate treatment of behavioural symptoms within systems that are continuously evaluated and modified to achieve desired outcomes
6. provision of the most appropriate setting for behavioural health services, including service provision in the home and community to the greatest extent possible and in the most integrated setting that fits the child's needs
7. timeliness
8. tailoring of services to children's and families' needs
9. stability and minimization of multiple placements, with emphasis on avoiding use of police and criminal justice systems inappropriately for child mental health placement and further emphasis on attention to the need for transition planning between placements and service agencies
10. respect for children and families' unique cultural heritages, including consideration of the family's primary language
11. independence, including support and training for parents as well as transportation assistance and assistance in understanding written documents
12. connection to natural supports from the family's own network of resources

The Bazelon's criteria are rights-based in the sense that they define service-delivery expectations to which children and their families are entitled. Other groups, such as the American Academy of Child and Adolescent Psychiatry (AACAP), have issued policy statements on service delivery to children and adolescents. For example, among AACAP policy statements, are statements on the psychiatric care of children in the foster care system, use of externally provided services, principles of universal access to services, and treatment of children and adolescents as inpatients. These organizations have recognized that service-delivery development for child and adolescent mental health cannot occur without identification and recognition of children's and adolescent's rights, as well as identification of the principles that will guide that system.

The MacDonald report identified solid principles for mental health service delivery in Saskatchewan. The Mental Health Services Branch (1990, p. 2) has identified a *Values Base*, which includes the following core values:

- leadership
- partnership
- respect for individual rights
- quality assurance
- self-determination
- efficiency
- fair and equitable allocation
- balanced service delivery system sensitive to client/patient needs
- priorities
- normalization
- service continuity

These values inform identified program objectives, operating assumptions, and the dual-axis framework for services previously described. In addition, some activity has occurred in Saskatchewan towards adoption of an integrated case management system. Recently, the Assistant Deputy Ministers' Forum on Human Services Interdepartmental Work Group issued their *Integrated Case Management Manual* (1999) in an effort to address systemic barriers and challenges in human service delivery.

Recently, Saskatchewan has introduced a process for the resolution of complex cases as a part of the School^{Plus} initiative. Individuals, including children, who have complex mental health issues combined with other factors such as insufficient family or community support and a high level of risk to harm themselves or others, might be identified as needing a "complex case strategy." An interagency team would be established and a management agreement developed to ensure that the individual is provided with a treatment and support strategy that includes a stabilization plan, a transition plan and a long-term support plan. This "complex case strategy" is a relatively new approach to supporting these individuals and families and the preliminary outcomes for the families are reported to be very positive (School Plus Community Service Delivery Model, Draft Framework and Guidelines, June, 2003).

A number of models exist with the goal of integrating case planning and service delivery to children, adolescents, and their families. For a broad-ranging overview of the great variety of models available for service delivery to children and youth, reference can be made to a recent report for the Department of Community Resources and Employment produced by the Forensic Psychology Laboratory at the University of Saskatchewan (2002). That particular report also contains a brief overview of programs and innovations within Saskatchewan with regard to child and adolescent program delivery.

What seems most apparent from a review of the literature regarding services to children, adolescents, and their families is that integrated service-delivery has become the banner under which program revisions have proceeded. Integrated service-delivery models derive from a model first identified in the mid-1980's by Sroule and Friedman, who described it as a "system-of-care model." This model has been adopted widely. The model is also referred to as the "continuum of care" (Bickman, 1996) and has become related to current "wrap-around care" models in foster placements and "multi-systemic care" models for adolescents with conduct problems.

According to Vinson, Brannan, Baughman and colleagues, (2001, p. 30), the system-of-care model is based on the following principles:

1. attention to the individual needs, preferences, and cultural characteristics of the child and family;
2. use of a strengths-based rather than a deficits-based, perspective;
3. involvement of families in their children's care and in program and system development;
4. cross-agency coordination and collaboration in service system management and service delivery; and
5. use of the least-restrictive service setting that is clinically appropriate.

While the system-of-care approach is popular, not many studies have been published evaluating service-delivery outcomes. However, studies that employ network analysis techniques have found a number of benefits to the system-of-care approach, including the following:

1. improvements in interagency networks
2. better system coordination [in the Fort Bragg project]
3. increases in the centralization of funding and client-referral networks in a "parent-designed" services system, while a traditional, "provider-designed" service system experienced decreases in the centralization of funding and information exchange networks
4. deterioration of system coordination under a capitated managed care system (quoted from Vinson, Brannan, Baughman, & colleagues, 2001, pp. 30-31)

Many researchers have not assessed cultural competence or family involvement effectively, despite the importance of these variables to the system-of-care model (Vinson, Brannan, Baughman, & colleagues, 2001).

In a study of the extent to which 27 programs were able to realize system-of-care basic principles, including the famous Fort Bragg project, Vinson, Brannon, Baughman and colleagues (2001) found that none of the programs were able to fully implement an ideal system-of-care. The system-of-care has been shown to have beneficial effects. However, the system-of-care model may be more idealistic than realistic in application.

6. Collaborating Across Sectors and Levels to Address Child and Adolescent Mental Health

In studying what is required to facilitate coordination between adolescent health centers and managed care organizations in the United States, Schwalberg and Hill (1995) recommended a number of ways in which organizations can improve their practice guidelines in order to improve access to mental health services delivered in non-traditional settings. Fundamental to opening up and maintaining school-based services to adolescents was the recognition that adolescents tend to underutilize health services and require targeted programming in settings that would result in a higher probability of adolescents attending on their own initiative.

Schwalberg and Hill (1995) identified a number of systemic and structural barriers within programs that need to be addressed in order to facilitate the opportunity for school-based clinics to be built and recognized by managed care agencies.
Although these barriers were specific to managed care, the general point can be taken that if collaboration across sectors and levels is to occur, those sectors will each have procedures, guidelines, and protocols that will have to be altered to remove barriers to inter-agency collaboration.

Zimmerman, Schwalberg, Botsko, Gallagher, and Borzsak (2001) reviewed a series of case study findings regarding barriers to mental and physical health services for children and adolescents. They found that effective interagency collaboration depends on a number of important factors, including (1) being able to make co-location of service delivery work; (2) sharing record-keeping; (3) focusing on family involvement in service delivery; (4) maintaining a high level of staff dedication to service delivery; and (5) focusing on successful outcomes for high-risk children.

Zimmerman, Schwalberg, Botsko, Gallagher, and Borzsak (2001) also identified a number of barriers to service collaboration and integration, including (1) ongoing separation of mental health and physical health services; (2) lack of strong partnerships between certain key agencies in the service matrix, particularly across professional disciplines; and (3) financial barriers. Zimmerman, Schwalberg, Botsko, Gallagher, and Borzsak (2001) recommended a number of specific remedies that could be taken by governments and community agencies in order to improve service access for children.

I. Service Fragmentation and Accessibility

Being able to identify and measure key indicators of mental health in the province requires cooperation and integration of information from a variety of sources. Mental health services to children and adolescents of Saskatchewan are divided, some would say fragmented, among numerous agencies, mental health regions, and professions. Peters, Lafreniere, and Digout (2001, p. 27) suggested that the "present system of care for child and youth mental health in Canada is often described as a 'collection of services'; [sic] plagued by an absence of valid outcomes measures, no external incentives, and no one responsible executive component." Steps have been taken in Saskatchewan to achieve less fragmentation through the *Integrated Case Management Manual* (Assistant Deputy Ministers' Forum on Human Services Interdepartmental Work Group, 1999) and Complex Case Management but more work needs to be done structurally and systemically to achieve what could be described as a system of care in the province.

Saskatchewan has 13 health authorities, all of whom offer a variety of mental health services to their residents. Each region is provided with the *Saskatchewan Mental Health Program: A Description of Services*, which contains "information and direction" but not requirements and accountability measures for core areas of service provision in Child and Youth Services, Adult Community Services, Psychiatric Rehabilitation Services, and Mental Health Inpatient Services.

Provincially funded mental health services for children and adolescents are delivered through district out-patient mental health clinics, which offer a range of services, including the following:

- Intake/Screening/Referral
- Assessment
- Case management
- Case consultation
- Treatment
- Family therapy
- Anger management
- Parenting education
- Eating disorder treatment
- Services for sexually abused children
- Adolescent sexual offender assessment
- Behavioural assessment, management and treatment
- Attention deficient hyperactivity treatment
- Services for sexually intrusive children
- Adolescent sexual offender treatment
- Suicide intervention and prevention/ psychosocial trauma response

(Taken from http://www.health.gov.sk.ca/ps_mental_health_youth.html)

The above list of services is descriptive, not prescriptive. As a consequence, not all district mental health clinics offer all of these services, creating uneven coverage for people in different parts of the province. In effect, the only regions in the province that offer all of these services are the health authorities of Regina-Qu'Appelle, Saskatoon and Prince Albert Parkland.

Child and adolescent mental health services are available through the Community Assessment Treatment Unit, a program of Mental Health and Addiction Services in the Saskatoon Health Region. This program has a bed capacity of five. Although, in the past, the program was part of Royal University Hospital and was regarded largely as an inpatient facility, it never formally had that designation. At one time, the program had six beds plus one respite-care bed but that no longer is the case (based on personal communication with senior official, Saskatoon Regional Health Authority). In addition to the Community Assessment Treatment Unit, Royal University Hospital has up to six beds for adolescent mental health, but these beds are on an adult unit. The Regina General Hospital has a small unit that will take adolescent admissions.

Due to a provincial lack of pediatric mental health inpatient units, children who require emergency hospitalization for a mental health problem could be, and have been, placed on adult psychiatry units, where neither developmentally appropriate surroundings, events, rehabilitative activities, nor staffing are present. Mental health services for children and adolescents are also provided in cooperation with a number of Health-funded mental health services, including the Rainbow Youth Centre and Autism Resource Centre, which are both in Regina, and the Saskatoon Society for Autism.

When Appropriate Services are Not Available

From time to time, children or youth require an admission to an in-patient psychiatric unit. In the absence of a child and youth in-patient facility, children are admitted to predominantly adult facilities in many health regions. A mother of a nine-year-old child contacted the Children's Advocate Office when she had concerns about the mental health services being provided to her daughter. Despite consensus by the child's pediatrician, psychiatrist and the health district administrative staff that a placement in a hospital pediatric unit would be in this nine-year old child's best interest, in the absence of qualified 24-hour psychiatric supervision on the pediatric unit, an out-of-province placement was being considered. Fortunately, with the collaborative and persistent efforts of all involved, the child was admitted to a pediatric unit and the matter was referred to a task group for further review. In a letter to the Children's Advocate, one of the physicians commented: "Sadly, the case of this particular child reflects a concern that has been expressed by physicians and other health care providers for many years regarding the inadequate resources to support appropriate care for children with behavioral and mental health conditions."

However, inpatient mental health services for children and adolescents in this province are virtually nonexistent. Currently some discussion is takingp lace regarding the building of an inpatient mental heath facility in Saskatoon; however, it remains to be seen what kinds of child and youth services actually will result from this planning. Saskatchewan Health has indicated that the Regina Qu'Appelle Health Authority plans to open a dedicated child and youth in-patient mental health service with ten beds in the spring of 2004.

II. Access to Services

Although access to mental health services has been identified as an indicator of quality mental health care by the Community Care Branch of Saskatchewan Health, accessibility continues to be a problem particularly for children and adolescents who require services in rural and remote districts. In addition, people who live in small communities may not want to access their local mental health service due to perceived problems with confidentiality and stigmatization. Integration of mental health service practitioners with primary care practitioners in these cases has been shown to reduce the stigma associated with accessing mental health services (Wagenfeld, Murray, Mohatt, and DeBruyn, 1997).

Access also remains problematic for children and adolescents who experience comorbidity (more than one diagnosable mental disorder at the same time) or a significantly reduced capacity for mental health due to extremely complex problems and life circumstances. However, children with relatively less complex problems also experience access difficulties due to long waiting times for access to services. For example, in comparison to adult community and rehabilitation services, child and adolescent mental health services report some of the longest waiting periods in terms of initial access to services. While people typically might be booked in for an appointment when they call a provincial mental health facility, some health districts reported waiting periods as long as 4-6 months before these people are actually seen (Community Care Branch, 2001). Long waiting periods are a testament to the fact that public need exceeds service/practitioner availability in Saskatchewan.

Long waiting periods also create a kind of class distinction in terms of service accessibility because those families who can afford to pay for private mental health services or who have secondary health insurance plans will be able to access private services much more rapidly that those families who must depend on publicly funded services because they cannot afford private services, have access problems, or live in areas of the province where services are not offered.

Long waiting periods for mental health treatment push many families to face the decision of whether to (1) pay for private services and have them delivered sooner; (2) suffer with their problem until they can access a publicly funded service; or (3) access a family physician for mental health service, placing the burden of mental health service funding on the primary healthcare budget. Accountability in terms of how these services are delivered or what outcomes are achieved would be important. Estimates exist demonstrating that "at least one-third of family practice patients have a diagnosable mental disorder; up to 60% have no diagnosable physicial disease and are suffering from primarily psychological problems" (Conway, 2003, p. 2).

Families have the opportunity to receive mental health services from a variety of professionals in the province. Conway (2003) identified three primary mental health specialists in Saskatchewan – psychologists, psychiatrists, and registered psychiatric nurses.

He also identified a number of health professionals in the general medical/primary care sectors of the province who may be expected to address mental health issues on their jobs but who may require additional training in mental health, including registered nurses, licensed practical nurses, and family physicians. For example, family physicians deliver two-thirds of physician-provided service for mental health in Saskatchewan (Conway, 2003). A recent report by the Saskatchewan Health Quality Council (January 2004) also indicated that primary care doctors play a vital role in detecting, treating and managing mental health problems. However their research suggests that there is room to improve mental health care in the primary care setting.

In addition, Conway also pointed out that registered social workers and unlicensed paraprofessionals carry out a significant amount of mental health work, with both groups identified as needing enhanced training regarding their scope of practice and basic competencies in clinical mental health practice.

No less than 22 pieces of legislation affect the delivery of child and adolescent services in Saskatchewan, including (Saskatchewan Mental Health, 2000):

The Mental Health Services Act
The Adoption Act
The Child and Family Services Act
The Child Care Act
The Children's Law Act
The Correctional Services Act
The Constitution Act
The Criminal Code of Canada
The Department of Social Services Act
The Dependants' Relief Act
The Dependent Adults Act
The Divorce Act
The Family Maintenance Act
The Freedom of Information and Protection of Privacy Act
The Hospital Standards Act
The Marriage Act
The Mentally Disordered Persons Act
The Public Health Act
The Saskatchewan Human Rights Code
The Youth Criminal Justice Act
The Youth Offenders' Services Act

This list does not include legislation governing the various professions who provide mental health, educational, or child-care services to children and adolescents. According to Saskatchewan Mental Health (2000), the list also does not include reference to standards of ethical and professional practice for the various professions involved in mental health service delivery, including:

- Health service accreditation standards
- Provincial standards of Saskatchewan Health
- District Health Board standards
- Common law and other legislative requirements
- Specific specialized service guidelines

Neither does it refer to *The Ombudsman and Children's Advocate Act* or professional policy statements on best practices in child and adolescent mental health.

In addition to the great variety of legislation, professions, and venues involved in mental health care, each profession has its own particular service mandate, which may or may not create possibilities for coordinated work in delivering services to children.

Some of the diversity of services involved in child and adolescent mental health include, to varying degrees, schools, correctional facilities, foster homes, therapeutic foster homes, child protection agencies, mental health clinics, family physicians, hospitals, voluntary organizations, children's social programs (e.g., Boys and Girls Clubs), social activist initiatives (e.g., against abuse of children by the sex trade), societies/special interest organizations (e.g., Autism Society), and specialty services (addictions, rehabilitation, comorbid conditions, low adaptive ability).

III. Culturally Appropriate Service Delivery

Culture remains a significant consideration in mental health service delivery for Saskatchewan. Cultural considerations in addressing the needs of immigrant and refugee populations within the province must be addressed, particularly with regard to poverty and use of health resources. In addition, there are increasing numbers of First Nations people moving to urban areas, where they often become ineligible for services from their own on-reserve agencies. This document cannot even begin to address the badly needed improvements in determinants of health for First Nations children and adolescents in Saskatchewan, which are considerable but which also fall largely under federal mandate (e.g., housing, clean water).

Better communication and coordination of services between provincial agencies and First Nations agencies is essential, with special attention given to case transfer protocols and funding arrangements when a child or adolescent of First Nations heritage moves to the city or from the city back to a reserve community. In addition, cultural competency of service providers has been identified in the psychological literature as crucial to effective service delivery to persons of cultures differing from that of the majority population. To date, most mental health agencies seem to have been sensitized to the need for cultural competency, but defining competency and identifying measurable standards for it remains an uncompleted task.

7. Employing Mechanisms for Public Involvement in Child and Adolescent Mental Health

Including public input into planning and decision-making regarding health services, including mental health services is certainly not a new concept in Saskatchewan. The former Saskatchewan Council on Children, for example, recommended that community engagement become a priority to encourage more responsive service delivery for Saskatchewan children.

The Council specifically recommended to the Ministers participating in Saskatchewan's Action Plan for Children (2002) that "The participation of community organizations and citizens would make a valuable contribution to the decision-making processes...regarding servicces that should be available and how they are organized. This would move the integration agenda closer to the grass roots level and would provide community members with access to decision-makers."

The Government of Saskatchewan established the Saskatchewan Mental Health Advisory Council, which includes up to 14 persons nominated by Regional Health Authorities or on the basis of their personal interest, experience and expertise in the field of mental health. This Advisory Council meets quarterly and advises the Minister of Health and senior officials in Saskatchewan Health on policies, programs, priorities and resources aimed at meeting the mental health needs of the people of Saskatchewan. In March, 2003, for example, the Mental Health Advisory Council, "in order to support appropriate treatment of mental health issues within the child and adolescent population," recommended that:

1. Children and adolescents requiring inpatient mental health services should not be placed on adult inpatient mental health units. Inpatient treatment should be offered in an environment that is sensitive to the safety and developmental considerations of children and adolescents as well as being appropriate for their mental health needs.

2. All mental health services for children and adolescents should be delivered in the least restrictive environment possible. Inpatient treatment should be used for only the most acute cases with consideration given to the safety of the client and others. The length of stay on the inpatient unit should be limited to the point where the child or adolescent is safe and appropriate for treatment in a less restrictive environment such as open custody residential care or discharged home with his/her family with follow-up support services arranged.

3. Inpatient mental health services for children and adolescents should complement other treatment approaches on the service continuum. While on the inpatient unit, mental health team members should utilize a well defined case management approach that includes support, advocacy, and facilitates linkages with necessary services for clients and family members (particularly Child and Youth Services and psychiatrists and/or psychologists). Considerations for age, developmental stage, situations, and conditions should be given. Both patient and family should be encouraged to participate in treatment and discharge planning as much as possible.

4. Ideally we would recommend child and adolescent designated beds in each Regional Health Authority; however, the recommended minimum service would be a designated mental health unit for adolescents. It may not be practical to have a child and adolescent specific inpatient mental health unit in every service area.

However, child and adolescent inpatient mental health units located in Prince Albert, Regina, and Saskatoon would provide access to persons in the northern, central, and southern regions of the Province. Furthermore, the adult inpatient mental health units in the aforementioned cities are the most frequently utilized at present by children and adolescents. It is recommended that the number of beds on each child and adolescent mental health unit be consistent with recent average daily census readings of children and adolescents on adult units in the respective regions.

5. Child and adolescent inpatient mental health units should be staffed with professionals possessing the educational background and skill-set necessary to work most effectively with the client group. Specific qualities include, but are not limited to, knowledge and experience of major mental illnesses and their treatment approaches, developmental and cultural issues related to children and adolescents, comprehensive knowledge of relevant community resources, and appropriate interpersonal skills to work with challenging clients. Service providers skilled in providing substance abuse treatment for children and adolescents should always participate on the team given the number of young people with both a substance abuse problem and a mental disorder.

6. Developmentally appropriate schooling, recreational, and socializing opportunities for children and adolescents should be available on child and adolescent inpatient mental health units. Conversely, the units should also be designed and staffed in a manner which permits for a highly restrictive treatment environment if necessary for certain children and adolescents with severe disorders. An example might be the development of a day hospital for use by inpatients and outpatients.

7. It is imperative that links be established and maintained with the educational jurisdiction to promote continuity while a youth is hospitalized. As well, outreach support to the educational community by the mental health professional should be provided to accommodate successful educational planning.

8. The Council recognizes that children and youth admitted as inpatient clients often have complex care needs. Policy and protocols should be in place for the involvement of appropriate service providers to address support needs for the young person to facilitate early and successful discharge. These agencies could include Social Services and other community support services.

9. The transition from Child and Youth Services to Adult mental health services should involve coordination from all relevant parties in order to facilitate continuous, consistent service provision and support for the client and family.

These examples of public involvement are significant; however, it is difficult to ascertain what action, if any, has been taken in response to the recommendations made by these citizen-based advisory bodies.

8. Demonstrate Accountability for Outcomes in Child and Adolescent Mental Health

Demonstration of accountability for outcomes in child and adolescent mental health fundamentally necessitates information gathering and management in a manner that provides meaningful, useful data for system outcome evaluation but that continues to respect the privacy of persons accessing the mental health or other publicly funded initiatives. In a comprehensive review of best practices in information management for mental health services, Goldner, Thompkins, and Cardiff (2001) communicated 48 provisional recommendations that would be worth reviewing as part of comprehensive information management system reform naturally occuring during mental health service integration initiatives. In Saskatoon, for example, an initial effort has been made to collect basic demographic and personal information about persons who access mental health services, as well as service frequency, service type, and professionals involved (Goldner, Thompkins, & Cardiff, 2001).

While effective information management is at the heart of program development, the impact of program reform on children and adolescents also must be considered. For example, reorganization or reform of services, itself, can deflect staff energies away from actual service delivery. Stroule, Pires, Roebuck, and colleagues (1997) conducted a survey of how state health care reforms affect children and adolescents with emotional disorders and their families. Only one-third of program reforms resulted in organized systems of care for children with serious mental health problems. Despite recognition that children and adolescents with severe emotional disorders require multi-agency involvement, two-thirds of reform initiatives did not involve movement to a system-of-care model.

These researchers found that most child and adolescent health service-delivery system reform initiatives involve some form of quality assurance system for outcome measurement and evaluation (Stroule, Pires, Roebuck, et. al, 1997). Cost was identified as the most frequently assessed variable, followed in order by access to services and service-use patterns (Stroule, Pires, Roebuck, et. al, 1997). Variables tending to receive the least amount of monitoring included treatment effectiveness and program effectiveness, meaning that client outcomes tend to take a back seat to program cost, access, and use. On the other hand, parental satisfaction with programs was often measured, and adolescent satisfaction also was measured sometimes (Stroule, Pires, Roebuck, et. al, 1997). Reforms focusing specifically on mental health service-delivery systems tended to measure outcomes across all variables more frequently than did reforms of strictly the physical health system.

Child and adolescent professional mental health staff typically participated in mental health care reforms, but when mental and physical health systems were being reformed at the same time, mental health staff had considerably less input into the reform process. In 15 to 37% of health and mental health reforms, mental health professionals had no input whatsoever (Stroule, Pires, Roebuck, et. al, 1997). Families had limited involvement, mostly through focus or advisory groups. In one-quarter of states reporting on reform processes, no families were involved in health care reforms at all.

Chessie (1998) identified several barriers to the regular incorporation of evaluation procedures into service delivery systems. Chessie identified three primary barriers to incorporation of evaluation in Saskatchewan mental health services: conflicting service and administrative boundaries, a lack of high-quality data, and a lack of evaluation resources. Recommendations for ensuring that continuous evaluation becomes a regular part of mental health service delivery were made, as well as ways for achieving this goal.

In 1994, Santa Barbara County in California formalized a comprehensive integration of children's services in an attempt to develop "a community-based system of care for children with serious emotional disturbances and their families" (Woodbridge, Furlong, Casas, and Sosna, 2001, p. 63). Because the integration process was funded by a federal grant, the County was required to submit data to a national evaluation of sites engaging in system of care programming so that systemic outcome evaluation could occur. Evaluation included input from all system stakeholders, including management, staff, and families accessing services.

The project, entitled the Multiagency Integrated System of Care (MISC), included an evaluation team, who developed several principles for project evaluation, a theory of change, as well as a model developed from this theory.

The MISC evaluation team theory of change, called "Precision of Fit," is based on the idea that optimal clinical and economic outcomes "are directly related to the fit between (1) child and family strengths and needs and (2) the level of care provided" (Woodbridge, Furlong, Casas, and Sosna, 2001, p. 67). Precision of fit was attained via a comprehensive assessment designed to identify child and family strengths as well as needs, and service delivery was evaluated in an ongoing manner to ensure continued precision of fit of needs with outcomes.

A culture of evaluation was cultivated within the project to the extent that evaluation became a valued activity to which family members, agency supervisors, and managers contributed. All parties developed a sense of shared responsibility in the process. Evaluation data provided vital information regarding the progress and experiences of families participating in the program, as well as treatment outcome.

> For example, when child and family risk factors were consistently displayed in the monthly reports, services staff was alarmed by the documented level of the severity of the needs and traumatic events encountered by youth and the co-occurring needs and traumatic events in the history of their households. These analyses were instrumental in empirically supporting the system of care with its focus on family needs and interagency collaboration (Woodbridge, Furlong, Casas, and Sosna, 2001, p. 69).

Achievement of broad-based support for evaluation was a significant achievement for the MISC program, given that utilization management evaluation processes are often viewed by clinicians as intrusive, inappropriate, and having a negative impact on treatment quality (American Academy of Child and Adolescent Psychiatry, 1990). Identification of measurable program goals was essential to program evaluation, and level of system effectiveness was tied to these goals. In addition, the program established specific principles to guide the evaluation process, such as frequent and open communication with MISC staff and promoting inclusiveness in the evaluation process, as well as providing consistent feedback on a monthly basis (p. 70).

The overarching goal was to produce evaluation outcomes that were meaningful to the people involved in the MISC program, which increased people's dedication to the evaluation process.

To achieve their goals for effective evaluation, the MISC team also implemented a specific process for collecting, processing, and analyzing evaluation data which involved staff training, ordering and distributing of evaluation materials, as well as timely feedback of results. Hughes, Rintelmann, Mayes, et al. (2000, p. 119) noted that persons who have achieved a bachelor's-level post-secondary degree "can be trained to administer a highly reliable diagnostic battery to meet a 'gold standard,'" which can provide for some cost efficiency in initial diagnostic evaluation procedures, particularly in the assessment of substance-use disorders and attention deficit disorders.

Other programs have published guidelines for program evaluation and administration in developing systems of care, and a thorough review of these would be advantageous prior to developing a new program model in the province (for example, see Rivard, Perry, & Hinkle, 1994; Children's Hospital San Diego, 1996).

In order to be able to evaluate program goals and effectiveness, a broad-based level of financial, infrastructure, and personnel support needs to exist within the service-delivery system. Mental-health administration and staff would need to see the value in this kind of evaluation process and should be able to benefit from a review of outcomes in their particular areas. Evaluation processes require specialized skills and professionals. Evaluation also requires that service-delivery process and outcome indicators be identified and tracked so that management and staff are able to see what works in service delivery and what does not.

Standards and recommendations for self-regulating service-delivery systems have been developed by Health Canada. The Saskatchewan Mental Health Program Review (2001) contains a section on indicators for quality of mental health care. Standards for excellence in pediatric health delivery systems have been published by the National Association of Children's Hospitals and Related Institutions (1996). In addition, many public agencies have moved towards a "results-based" decision-making process for program evaluation and subsequent budgeting (see, for example, the Los Angeles Children's Planning Council, http://www.raguide.org/los_angeles/_Childrens_Planning_Council.htm). The MacDonald task force published recommendations for evaluation, and other models also have been published for outcome evaluations (see, for example, Jensen, Hoagwood, Petti, 1996).

9. Synopsis of the Research

In Saskatchewan, many programs exist in the area of child and youth mental health; however, what outcomes are achieved remain, for the most part, unknown. The statement "if it's not being measured, you don't know about it" can be applied at the most fundamental level for mental health service delivery in the province. Better tracking of mental health service use as well as outcomes would be only a first step in terms of determining the adequacy of mental health service delivery to children and adolescents in the province.

Service integration and coordination could be described as a pressing need in Saskatchewan. However, this integration and coordination needs to have equal investment from equal partners in the process and cannot be subjected to the organization or total control of one partner. Attention to the rights of children, adolescents, and their families, as well as a process for external review of mental health service delivery is essential.

The final conclusions and recommendation from this report are meant to address specific concerns arising out of this report. They are not meant to be all-encompassing, but constitute the most important areas of immediate need in development of a strong system-of-care for mental health service delivery to children and adolescents. Saskatchewan has always had a history of innovation in the area of mental health; however, despite innovations and increased resources, there are still many unmet mental health needs for children and youth in Saskatchewan. It is difficult to see what has changed since the MacDonald task force in 1983. The time is ripe to recapture that history of innovation and make real, positive changes for mental health service delivery to Saskatchewan children, adolescents, and their families.

Part 5
Conclusions and Recommendation

This report examined issues and concerns regarding the quantity, quality, and accessibility of mental health services for children and youth. We have attempted to provide this analysis in a Saskatchewan context; however, this has been a challenge given the limited data available in our province.

It is difficult to see what has changed since the MacDonald task force in 1983. While some of the recommendations may have been implemented and many no longer apply, new problems have developed over the past two decades. The Mental Health Services Branch has been restructured since 1990 and it is difficult to ascertain exactly what conceptual framework is being used for children's mental health services in Saskatchewan at this time. Therefore this report is only a first step in determining the full state of the Saskatchewan government's level of ongoing commitment to mental health services for children and adolescents in the province.

Based on Health Canada's eight key elements to reduce inequalities in health status, the CAO has identified several issues with the current mental health system in Saskatchewan which we believe require further analysis and then action.

Data Collection & Evaluation

There is no comprehensive data collection system, consistent with a population health model, to track and report on the status of child well-being or to track the prevalence of mental disorders for children and adolescents in Saskatchewan. Saskatchewan Health does track some health services and outcome indicators, albeit limited (such as at-risk birthweight, adolescent pregnancy and substance abuse). No longitudinal data is available on provincial mental health services for children and youth or about determinants of health, and determinants of mental disorder. This information would need to be gathered centrally, over time, and consistently, while also maintaining respect for privacy regarding the health data collected. In addition, no process exists to evaluate the success or appropriateness of current services through broad-based performance measurements or outcomes indicators.

In addition, we did not examine the limited Saskatchewan data in relation to other jurisdictions in Canada. We believe that there would be a benefit in completing this interjurisdictional comparison to help determine the level of mental health services needed in Canada, not to mitigate the Saskatchewan expense. At this time, Saskatchewan Health does have a mental health information system which records, in a very limited way, certain demographic information.

The Saskatchewan Mental Health and Alcohol and Drug Program Reviews done annually by Saskatchewan Health are a step in the right direction. This information would assist governments, universities and mental health professionals in establishing policies, as well as initiatives, for addressing the mental health needs of children and youth in the province.

Integration of Services and Coordination/ Collaboration Across Service Sectors

Although several models for integrated service delivery have been introduced over the past number of years, they are either implemented on a limited basis or have not been actualized. In order to develop strong systems of care, a more co-ordinated integrated system across government departments, service delivery agencies, disciplines and administrative structures is necessary, including consideration of:

- Integration of mental health services with primary health care
- Integration of services with schools
- Co-location of interagency staff
- Interagency database integration (keeping with the established procedures for ensuring confidentiality)
- Family involvement in the mental health system
- Integrated case management and other collaborative models
- Comprehensive assessment procedures
- Openness to external investigation and review

Clearly schools provide a unique vehicle through which children and adolescents' mental health problems could be addressed. The introduction of the School[Plus] Model would seem to be a positive step toward a fully integrated system.

The CAO supports the seven basic principles or characteristics identified by the MacDonald Task Force for a good mental health service-delivery system:

1. **That health is a state of complete physical, mental and social well-being and not merely the absence of disease.**
2. **That every individual has the right to expect an environment which promotes health, both physically and psychologically.**
3. **That every person in Saskatchewan must recognize that they have a role to play in the maintenance of their own and everyone else's mental health.**
4. **That neither stigma nor blame should be attached to those suffering from mental illness.**
5. **That every person has the right to expect equivalent care, consideration and acceptance, regardless of whether they are suffering from a physical or mental illness.**
6. **That a comprehensive Mental Health program should direct itself to prevention as well as to treatment and rehabilitation.**
7. **That a comprehensive mental health system should:**
   - **Be sensitive to the changing mental health needs of the population it serves.**
   - **Be accessible to all, regardless of age, sex, cultural background or place of residence.**
   - **Provide appropriate services for the diverse needs of its individual clients.**
   - **Be effective and efficient.**
   - **Be accountable to the public it serves, as well as its funding agencies.**
   - **Be conscious of the need for maximum community involvement in the planning and delivery of mental health services.**

Through School^{Plus} the Government of Saskatchewan supports the principle that all services to children and youth in the province be delivered in a truly integrated environment that is school-linked and, where possible and feasible, school-based. However many questions and issues still exist with the implementation of this model and, to date, School^{Plus} appears to be more of a concept rather than a reality.

Training, Recruitment & Retention

Saskatchewan continues to need more qualified mental health professionals in both the service delivery and research sectors. In addition, the pervasive separation between researchers and clinicians could be reduced by more collaboration between these two systems.

Access & Resources

There are not enough resources to meet the current demand for mental health services in the province, let alone the unrecognized population of children and youth who have not been identified as in need of service. The separation of mental health services with primary health care has resulted in, what appears to be, an inequitable distribution of health funds for mental health services. Revenue would also be required in order to resolve other areas of concern, such as recruitment and retention of staff, effective data collection and evaluation, research, and integration of services.

In addition to resource issues, other access issues were identified, such as:

- the discrepancy in outpatient and residential mental health treatment programs from one area of the province to another, as well as between various Regional Health Authorities
- access to specialized services for high-risk groups such as hospitalized children and children of psychiatric patients
- how funding is allocated on a per-child basis from one region to the next

Resources for mental health services needs to become a higher priority in the health care system.

Early Intervention, Prevention and Public Education

Over the past number of years, increased attention has been placed on investing in early intervention and prevention programs. Although the changes have led to many improvements in programming and services, more can still be done. There is currently no clear link between mental health services and early intervention programming, including early diagnosis and screening services at specific developmental stages of the pre-school and early school years. Public education, prevention, and research are essential components of comprehensive health programs and, like other areas of health services, require funding and support.

Best Practices

Mental health services for children and youth continue to focus on fitting the child or youth to the existing services rather than defining or tailoring the service to meet the needs of the child. Research suggests that best practices in mental health service delivery would address such issues as:

Age Appropriateness

- Considering age-related change along with the developmental conditions that may have impacted on the sustainability of treatment policies
- Providing adequate paediatric mental health inpatient units, to ensure that children are not being placed on adult psychiatry units where the surroundings, events, rehabilitative activities and staffing are developmentally inappropriate

Meeting the Child's Needs

- Providing the most appropriate setting for behavioural health services, including service provision in the home and community to the greatest extent possible and in the most integrated setting that fits the child's needs
- Stabilizing and minimizing the number of placements, with emphasis on avoiding use of police and criminal justice systems inappropriately for child mental health placements; further emphasis on attention to the need for transition planning between placements and service agencies
- Applying multiple strategies in addressing child and adolescent mental health
- Implementing policy and processes to ensure participation of the child or adolescent in the decisions regarding service delivery

Meeting the Child's Needs within the Family

- Tailoring of services to children's and families' needs and connection to natural supports from the families' own network of resources
- Ensuring that child and adolescent services have a broad enough mandate to be able to address families and their multiplicity of needs
- Respecting children's and families' unique cultural heritages, including consideration of the family's primary language

Administration Factors

- Case transfer protocols and funding arrangements when a First Nations child or adolescent on or off-reserve requires mental health services
- Cross-agency co-ordination and collaboration in service system management and service delivery
- Consistency from one regional health authority to another
- Equal accessibility to services for children in rural and remote areas
- Timeliness of service

Community Involvement

Some mechanisms have been initiated for public input into child and adolescent mental health service delivery. The former Saskatchewan Council on Children, for example, recommended that community engagement become a priority to encourage more responsive service delivery for Saskatchewan children. The Saskatchewan Mental Health Advisory Committee has been developed to advise the Minister of Health in Saskatchewan. They have made nine recommendations to support appropriate treatment of mental health issues within the child and adolescent population. These examples of public involvement are significant; however, it is difficult to ascertain what action has been taken in response to the recommendations made by these citizen-based advisory bodies.

Response From Saskatchewan Health

In January 2004, Saskatchewan Health advised the CAO of its recent progress in a number of mental health and related service areas:

- The Regina Qu'Appelle Health Region plans to open a designated child and youth in-patient mental health service with ten beds in Spring 2004.
- Recently, the Saskatoon and Regina Qu'Appelle Health Regions have employed psychiatric nurses in emergency rooms of their largest urban general hospitals to provide triage services to ensure the optimal use of hospital and community mental health services to meet the needs of patients.
- Over the past several years, the capacity of regional health authorities to provide psychological and psychiatric consultation to youth in custody facilities who present with challenging mental and behavioral issues has been increased.
- Regional health authorities throughout the province continue to provide specialized in-patient and out-patient alcohol and drug assessment services and treatment for youth identified through Correction and Public Safety's new risk assessment system as having alcohol and drug problems.
- An agreement reached a few years ago between the Saskatoon Health Region and the Department of Community Resources and Employment (DCRE) allows youth who are clients of DCRE to have first right of access to three dedicated beds at Calder Centre, a provincial alcohol and drug residential treatment program (for children, youth and adults).
- Since the Integrated Case Management model was introduced by the Human Services Integration Forum (HSIF) in 1998, many integrated case management initiatives for children and youth with challenging behaviors led by or involving Health have been developed including the Coordinated Behavior Management Initiative, the At Risk Child and Youth Program, the Randall Kinship Centre, the High Risk and Violent Young Offender Initiative and the Complex Needs Case Initiative.

Saskatchewan Health was given an opportunity, in accordance with provisions in *The Ombudsman and Children's Advocate Act* to comment on a preliminary version of this report. We appreciated their comments and, when we deemed it appropriate, incorporated these into the body of this report. In addition, Saskatchewan Health advised the CAO of recent progress in a number of mental health and related service areas and we decided to include this information in this report in order to ensure that all of the information we received from Saskatchewan Health was adequately represented.

Recommendation

This report is intended to be a catalyst for creating a comprehensive plan of action to ensure adequate and appropriate children's mental health services throughout Saskatchewan. Our observations lead us to conclude that we need a clear direction and vision for children's mental health services; a direction that reflects what is known about best practices and which includes data collection, analysis and an evaluation of the effectiveness of the services. We need to know that children are indeed accessing the mental health services and supports they need in a timely and effective manner. Right now, while there are some indicators of success, there does not appear to be a clearly articulated plan to ensure that all children, and their families, can access the supports or services they need.

Therefore, the following recommendation is made in accordance with section 24 of *The Ombudsman and Children's Advocate Act*:

CAO Mental Health Services Recommendation 2004

That Saskatchewan Health, in consultation with stakeholders, develop and implement a comprehensive plan to ensure that mental health services are provided to Saskatchewan children, youth and families in a manner that is consistent with what is known about best practices.

In addition, and in accordance with section 25 of *The Ombudsman and Children's Advocate Act*, the Children's Advocate is requesting:

Response

That Saskatchewan Health provide a response to this recommendation indicating the steps taken to give effect to this recommendation by January 2005.

Appendix A
Terms of Reference/Duties

Schedule A

Statement of Duties Respecting
Consultant/Advisor to the Saskatchewan Children's Advocate Office Review of the Quality and Quantity of Mental Health Services for Children in Saskatchewan

1. Assist with the selection of a researcher/writer to work with the Children's Advocate Office on this project.

2. Advise the Children's Advocate Office in the establishment of the Terms of Reference, Definitions and general parameters of the project.

3. Establish, with the Children's Advocate Office, specific objectives/tasks/outcomes for the project.

4. Advise and guide the work of the researcher/writer as he/she proceeds with completing the tasks. This would include meeting as required with the researcher/ writer and reviewing his/her work in progress.

5. Provide advice and expert opinion regarding the final report/paper to the Children's Advocate Office; provide editorial input and draft recommendations for future action. The final editing and final report will be the responsibility of the Children's Advocate Office; however, Dr. Randall's input into this final report will be formally acknowledged.

6. Provide other consultation and advice as requested and agreed to with the Children's Advocate Office.

7. Prepare a comprehensive report reviewing children's mental health services as per the outline/parameters attached. Report will be based on a review of documents/ reports and other materials, and will be provided to the Children's Advocate as a completed report with all references documented using APA style.

8. Provide interim updates (at least once monthly) on progress of the report to the Children's Advocate and the Consultant (Dr. David Randall).

Schedule A

Statement of Duties Respecting
Researcher/Writer to the Saskatchewan Children's Advocate Office Review of the Quality and Quantity of Mental Health Services for Children in Saskatchewan

9. Work with the Children's Advocate and the Consultant to complete any final editing that may be requested. Dr. Zolner to be identified and acknowledged on the final document only with her consent after she has reviewed the final version of the document.

10. Maintain the confidentiality of all information (except documents already in the public domain) obtained in the course of completing this project.

Proposed Outline and Parameters for the Project:

Assumptions:

- Child will be defined as a person under age 18 in accordance with *The Ombudsman and Children's Advocate Act*.
- Services provided by provincial government departments or agencies, as defined in *The Ombudsman and Children's Advocate Act* will guide definition/ parameters of services to be examined.

Questions to be examined:

1. What is the background/purpose of this review?
   - Set in terms of *The Ombudsman and Children's Advocate Act* and the work of the CAO
   - Use the United Nations Convention on the Rights of the Child as a framework for the 'ideal' state

2. What are the current policy directives (initiatives or directions) in place regarding children's mental health services in Saskatchewan and how do these compare with what is known about 'excellence' in this regard? These policies could be examined in relation to determinants of health, incidence and prevalence data, priorities for service, and what is necessary for minimum competence.

   Specific policies/guidelines used by Saskatchewan Health combined with some other government-wide initiatives such as School^{Plus}, the Integrated Case Management Model (AGM Forum), Health Futures reports such as the Fyke report, the Romanow report or the De V. Peters report to be used as the basis for this section.

3. What principles/values are used (and/or recommended in the literature) to orient and set criteria for children's mental health services in Saskatchewan and elsewhere in Canada?

4. What issues could be or should be examined?
   This could include, but is not limited to:

   - Mental health services for Aboriginal peoples (a la Royal Commission recommendations?)
   - Taxonomy/epidemiology systems used to define/describe mental health
   - Availability and appropriateness of in-patient and other residential services for children, including post-care follow-up support services
   - Staffing issues such as vacancy/turn-over, professional drift, training, credentials, professional development
   - Other cultural considerations, such as services for immigrant children and their families
   - Services for gay/lesbian and transgendered children/youth
   - Authority of the provincial department of health vis-á-vis the regional health authority and the impact of service delivery models in various geographic areas of the province.
   - Other?

5. What quality assurance/program evaluation models are effective and what is in place in Saskatchewan? (For example: patient advocate; indicators of performance used by the Regional authorities and Sask. Health; accreditation process; self-examination/self-report; role of professional colleges and national associations; evaluation of spending/resources/allocation of funds for prevention; are the programs based on evidence of quality or efficacy of the services)

6. What questions may require further exploration/consideration that are beyond the scope of this review? (For example: specialized programs and services for hard to serve groups with low incidence rates or others; ADHD; FAS/FAE; secure care issues; severe behavior problems combined with violence; dual diagnosis issues re: addictions and/or cognitive impairments; eating disorders; children who have been traumatized, etc).

7. What seems to be missing? What don't we know? What further work needs to be done to more fully understand this issue?

8. Based on this review of documents, what next steps/advice/recommendations could we suggest to the provincial government?

9. How will we best communicate this information in a public manner?

Appendix B
Overview of Child and Youth Mental Health Services

Overview[1]

CHILD AND YOUTH MENTAL HEALTH SERVICES IN SASKATCHEWAN

- Mandate of Child and Youth Mental Health Services
- Service Delivery Principles for Child and Youth Mental Health Services
- Description of Current Child and Youth Mental Health Services
- Role of Child and Youth Mental Health Services
- Criteria for Prioritization of Child and Youth Mental Health Services
- Recent Child and Youth Mental Health Service Initiatives Involving Other Sectors
- List of Child and Youth Mental Health Services in Regional Health Authorities

[1] Saskatchewan Health provided this overview to the Children's Advocate Office in January 2004.

Mandate of Child and Youth Mental Health Services

The purpose of child and youth mental health services delivered through health regions in Saskatchewan is to promote, preserve and restore the mental health of children and youth directly through the provision of care and services, and indirectly through the support to other service sectors involved with children and youth.

Child and Youth Mental Health Services operates in accordance with a number of guidelines including provincial and federal legislation, standards of ethical and professional practice and standards for health services accreditation and regional health authorities.

Service Delivery Principles for Child and Youth Mental Health Services

Some of the key principles guiding the delivery of child and youth mental health services include:

- **Client-Centered in the Context of Family**: Mental health services meet the unique needs of the child or youth in his or her special circumstances and are sensitive and responsive to age, developmental, gender and cultural differences. Children and youth are treated in the context of their families because of their critical influence on the children and youth;

- **Services Based on Need**: Services are provided on the basis of need with those with the greatest need given the highest priority;

- **Voluntary Consent to Most Services**: Most services for children and youth are provided on a voluntary basis in the community. (Only rarely is a child or youth treated involuntarily because he or she is suffering from a mental disorder in need of treatment and as a result of the mental disorder they pose a risk to self and/or others, or at risk of substantial physical or mental deterioration and the child or youth does not have the capacity to make an informed decision about the consequences and need for treatment.);

- **Confidentiality**: Information on the child or youth and his family is confidential in order to protect their anonymity and integrity. This is especially important for children and youth and their families with mental health challenges because of their often heightened sensitivity and the stigma of mental disorders. Therefore, typically information is shared on a need-to-know basis with the client's informed written consent. (Under certain rare circumstances, such as imminent danger to self or others, information may be shared without consent to prevent serious injury or death.);

- **Use of a Clinical Health Model or Diagnosis**: A diagnosis is not a label but an understanding of the nature and extent of the emotional or mental disorder the child or youth has, its likely causes, its likely course without treatment and recommended treatment;

- **Use of Evidence-Based Practices**: The use of practices based on evidence about their effectiveness and efficiency;

- **Use of Public Health Model**: The use of a model that looks at services in terms of levels of prevention – primary, secondary and tertiary prevention depending on the state of symptom or problem development;

- **Use of a Population Health Promotion Model**: This model takes into account all the determinants of the individual's or group's health and well-being to optimize the individual's or group's emotional and mental functioning;

- **Coordination and Collaboration**: Services are coordinated and integrated with other services and programs within and across human service sectors;

- **Least Restrictive Setting**: Services are provided in the community or in the least restrictive manner possible;

- **Services as Close to Home as Possible**: Services are provided as close to home as possible;

- **Client Participation in Decisions Affecting Client's Life**: Children and youth and their parents are encouraged and supported to participate in decisions affecting their lives as much as possible.

Range of Child and Youth Services	
As part of the direct mental health services	*In support of the indirect mental health services*
Intake/Screening/Referral Assessment: ▫ General ▫ Psychiatric ▫ Psychological Treatment: ▫ Individual ▫ Family ▫ Group ▫ Psychopharmacological	Program Consultation Education and training Clinical Consultation

Description of Current Child and Youth Mental Health Services

The following table outlines the range of services that may be provided by mental health clinics for children and youth through regional health authorities.

In Saskatchewan regional health authorities provide mental health services for children and youth including outpatient and community services as well as inpatient hospital services for acute care.

The regional health child and youth mental health services are delivered by multi-disciplinary teams of mental health or allied professionals which may include community mental health nurses, psychiatrists, psychologists, social workers, psychological assistants, therapists, and in the larger centres, speech/language pathologists, occupational and physiotherapists, using a range of individual, group and family approaches to assist and treat children and youth. These mental health professionals also work collaboratively with collateral agencies, individuals and communities to maximize the development and effectiveness of the informal mental health services for children and youth provided by other service sectors.

There are nine inpatient mental health services throughout the province for acute care – Regina, Saskatoon, Yorkton, North Battleford, Moose Jaw, Weyburn, Swift Current and Prince Albert. These acute inpatient services are primarily geared to adults but do admit children and youth. In Saskatoon, the inpatient services have six dedicated beds for children and youth. Currently in Regina, an adolescent ward accommodates some children and youth with acute mental health needs requiring hospitalization. In Spring 2004, the Regina-Qu'Appelle Health Region plans to open a designated child and youth inpatient mental health service with ten beds. In addition, there is one (currently five bed) short-term assessment and treatment residential unit (Community Assessment and Treatment Unit) serving the province and located in Saskatoon. There are also a few mental health approved homes for children and youth with mental disorders requiring out of home living arrangements in the province and these are in Saskatoon. Other residential services for children and youth in Saskatchewan may be accessible through the Department of Community Resources and Employment (DCRE). Child and youth mental health services can be accessed through the numbers listed on page 88.

Role of Child and Youth Mental Health Services

The child and youth mental health system provides assessment, treatment and case consultation in addressing the primary mental health needs of children and youth who are acutely ill and/or traumatized (e.g., suffering from post-traumatic stress syndrome, a brief psychotic reaction, an acute eating disorder, extreme anxiety or serious and repeated suicide attempts) as well as those who are disabled with severe mental disorders (e.g., psychosis, schizophrenia, major depression or mood disorders, severely behaviourally

disordered or chronically difficult to manage, pervasive developmental disorders including autism). It also works closely with the service providers to ensure there is a consistent, comprehensive and integrated plan to meet the needs of these clients with serious mental health challenges.

The child and youth mental health system also supports through program consultation, education and training other service providers who deal with young people with mental health issues.

Criteria for Prioritization of Child and Youth Mental Health Services

The following criteria are used to determine priority for child and youth mental health services within a community setting regardless of the source of referral (except for court-ordered assessments which are mandated):

- degree of risk of danger or impairment/injury to self or others;
- degree of short/long-term impairment for self-care;
- severity of mental distress caused by symptoms;
- relative effect of delayed intervention;
- underlying strength of support system;
- severity of acute distress in support systems;
- role and responsibility of other agencies and the community.

Recent Child and Youth Mental Health Service Initiatives Involving Other Sectors

Over the past decade or so Saskatchewan Health has provided funding for a number of new intersectoral initiatives for children and youth at risk, including:

- The Successful Mothers Support Program, located in 15 sites across the province, provides home and community-based support, mentoring and parenting advise to families with preschool children living in disadvantaged conditions;
- The Early Skills Development Program in Battlefords and Saskatoon provides intensive early intervention school- and home-based programming to assist Kindergarten and Grade 1 children with very persistent aggressive and violent behaviours to develop more socially acceptable behaviours;
- The Middle Childhood Support Project in Saskatoon is a case management initiative supported through a partnership between the local school divisions and Child and Youth Mental Health Services for children with social, emotional and behavioural challenges that compromise their academic progress and have not been well served by traditional services;
- The Coordinated Behaviour Management Initiative, located in 11 health regions, mainly provides integrated case management for children and youth with very challenging behaviours;
- The At Risk Child and Youth Program in Prince Albert, Regina, Saskatoon, the

Battlefords and Yorkton provides programming for children and youth who are or could be involved in the youth criminal justice system without this intervention;

- Mental health and addictions services integration for young offenders in Regina through the expansion of mental health and alcohol and drug services to promote the reintegration of incarcerated youth into the community;
- The Youth and Family Support Project in Saskatoon to provide integrated services to difficult-to-engage youth with serious mental health and alcohol and drug issues;
- The Youth Services Model Pilot Projects in Prince Albert and Regina aim to reduce reliance on the youth criminal justice system as a way to address the needs of youth with misconduct;
- The High Risk and Violent Young Offender Initiative in Prince Albert, Regina, Saskatoon, the Battlefords and Yorkton to reintegrate and rehabilitate high risk and violent young offenders.

List of Child And Youth Mental Health Services In Regional Health Authorities

ATHABASCA HEALTH AUTHORITY
Box 124
Black Lake, SK S0J 0H0
Phone: (306) 439-2200
Fax: (306) 439-2212

CYPRESS REGIONAL HEALTH AUTHORITY
350 Cheadle Street West
Swift Current, SK S9H 4G3
Phone: (306) 778-5280
Fax: (306) 778-5408

FIVE HILLS REGIONAL HEALTH AUTHORITY
455 Fairford Street East
Moose Jaw, SK S6H 1H1
Phone: (306) 691-6464
Fax: (306) 691-6461

HEARTLAND REGIONAL HEALTH AUTHORITY
2 – 122 – 2nd Avenue West
Box 1300
Rosetown, SK S0L 2V0
Phone: (306) 882-6413
Fax: (306) 882-6474

Box 459
Wilkie, SK S0K 4W0
Phone: (306) 843-2644, ext. 229
Fax: (306) 843-3222

1003 – 1st Street West
Kindersley, SK S0L 1S2
Phone: (306) 463-8284
Fax: (306) 463-5520

KEEWATIN YATTHÉ REGIONAL HEALTH AUTHORITY
Child and Youth Mental Health Services
Box 40
Buffalo Narrows, SK S0M 0J0
Phone: (306) 235-5847
Fax: (306) 235-4686

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
Box 1480
Melfort, SK S0E 1A0
Phone: (306) 752-8767
Fax: (306) 752-8711

MAMAWETAN CHURCHILL RIVER REGIONAL HEALTH AUTHORITY
Box 6000
La Ronge, SK S0J 1L0
Phone: (306) 425-4836
Fax: (306) 425-4840

PRAIRIE NORTH REGIONAL HEALTH AUTHORITY
Don Ross Centre
891 – 99th Street
North Battleford, SK S9A 1E9
Phone: (306) 446-6500
Fax: (306) 446-6546

PRINCE ALBERT PARKLAND REGIONAL HEALTH AUTHORITY
Victoria Square, Lower Level
2345 – 10th Avenue West
Box 3003
Prince Albert, SK S6V 6G1
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